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CHARLES ELMORE CROPLEY

IN THE

Supreme Court of the United States

OCTOBER TERM, 1951.

No. 507

ALFRED SYLVANUS, ARCADIA NATIONAL INSURANCE COMPANY AND VOYLE CLARK JOHNSON,

Petitioners,

vs.

THE UNITED STATES OF AMERICA,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT AND BRIEF IN SUPPORT THEREOF.

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No. .....

ALFRED SYLVANUS, ARCADIA NATIONAL INSURANCE COMPANY AND VOYLE CLARK JOHNSON,

Petitioners,

vs.

THE UNITED STATES OF AMERICA,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT.

To the Honorable Chief Justice and Associate Justices of the Supreme Court of the United States:

Alfred Sylvanus, Arcadia National Insurance Company and Voyle Clark Johnson, defendants in the trial court, and Petitioners here, pray that a writ of certiorari be issued by this Court for review of judgments (R. 938-939) entered in this case on December 1, 1951, by the Court of Appeals for the Seventh Circuit.*

*The opinion of the Court of Appeals appears at pp. 919-37 of the Record.

SUMMARY STATEMENT OF MATTERS INVOLVED.

The Nature of the Case.

The judgments of the Court of Appeals, sought to be reviewed, affirm a judgment of the United States District Court for the Northern District of Illinois, Eastern Division, entered on the verdict of a jury finding the Petitioners guilty: (1) of using the mails to execute a scheme to defraud by issuance of allegedly deceptive accident and sickness insurance policies, and by circulation and publication of allegedly misleading advertising matter relating thereto; and (2) of a conspiracy to commit the same offense. Sylvanus was sentenced to 3 years; the Insurance Company was fined $10,000; and Johnson was sentenced to 18 months.

The statutes under which the defendants were convicted are, so far as material, as follows:

> "Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises * * * shall for the purpose of executing such scheme or artifice or attempting so to do, place, or cause to be placed, any letter, postal card, package, writing, circular, pamphlet, or advertisement * * * in any post office * * * or authorized depository for mail matter, * * * or shall take or receive any such therefrom * * * shall be fined not more than $10,000, or imprisoned not more than five years, or both."
>
> Sec. 1341 (formerly 338), Title 18, U. S. C.

> "If two or more persons conspire either to commit any offense against the United States, or to defraud the United States in any manner or for any purpose, and one or more of such parties do any act to effect the object of the conspiracy, each of the parties to such conspiracy shall be fined not more than $10,000, or imprisoned not more than two years, or both."
>
> Sec. 371 (formerly 88), Title 18, U. S. C.

The offense charged has two elements:

(1) The existence of a scheme to defraud by issuance of the fraudulent policies and advertising matter; and

(2) The use of (or conspiracy to use) the mails to execute the scheme.

While the use, or contemplated use, of the mails is what gives the Federal Court jurisdiction, the conviction depends on the existence of the fraudulent scheme which is to be executed by their use—in this case, on an adjudication by the Federal Court that the insurance policies and advertising matter are deceptive and misleading, so that their issuance and publication would constitute a fraud.

The Basic Question of Federal Law Involved: Is This Prosecution Barred by the McCarran Act Delegating Exclusive Right of Regulation of the Insurance Business to the States, and Providing That No Act of Congress Not Specifically Relating to Insurance Shall Invalidate, Impair or Supersede a State Law Exercising That Right?

The insurance policies and advertising matter on which the prosecution is based, were issued and published in the conduct of an insurance business regulated by a statute of Illinois, known as "The Illinois Insurance Code," the material provisions of which are set forth in Appendix 1, attached hereto. That statute prescribes the form of insurance policies to be issued; requires their approval by the State Department of Insurance before issuance; prohibits misleading statements in advertising; and prescribes penalties for its violation.

The insurance policies in suit were specifically approved in form and substance by the State Insurance Department (R. 171-2) and were issued pursuant to state authority.

The purpose and effect of the prosecution were thus to

convict the defendants, under the Federal statutes relating to mail fraud and conspiracy, for acts done in the conduct of an insurance business wholly regulated by state law. The result was, as we contend, to nullify and to supersede that law and the regulations imposed thereby, insofar as they relate to the insurance policies and advertising matter in suit.

By Act passed in 1945, known as "The McCarran Act" (Secs. 1011-1015, Title 15 U. S. C.), Congress declared that regulation of the insurance business by the states is in the public interest and that "no act of Congress not specifically relating to the business of insurance" shall be construed to invalidate, impair or supersede any law enacted by any state for the purpose of regulating the business of insurance."

The McCarran Act, so far as material, reads as follows:

> **"An Act to express the intent of Congress with reference to the regulation of the business of insurance.** [Laws of 79th Congress, 1st Session; Public Law 15.]
>
> "Sec. 1—Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of Congress shall not be construed to impose any barrier to the regulations or taxation of such business by the several States. [Sec. 1011, Title 15 U. S. C.]
>
> Sec. 2—(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance. * * * [Sec. 1012, Title 15, U. S. C.]"

The basic question in this case is whether, in view of the McCarran Act, this prosecution under the mail fraud and conspiracy statutes, or a similar prosecution under any Federal statute, not by its terms relating to the conduct of an insurance business, can be maintained—*i. e.*, whether or not the McCarran Act leaves to the states the right to regulate and control the conduct of an insurance business, and excepts from the application of every Federal statute (not expressly relating to insurance) all matters pertaining to an insurance business over which the state, by appropriate legislation, has assumed jurisdiction.

This question was raised in the District Court on motion to dismiss the indictment, which was overruled (R. 25, 27).

If the motion to dismiss had prevailed, the Government would have had the right to appeal directly to the Supreme Court (Sec. 3731, Title 18 U. S. C.). The defendants have no corresponding right of appeal, but the question of statutory construction involved is important and, we submit, should be passed upon by this Court. It relates to the method of regulation of, and the power to regulate, the business of all insurance companies throughout the country that sell insurance policies by mail and by public advertising, rather than by personal solicitation.

The decision of this Court is further called for because of the conflict in principle between the decision of the Court of Appeals of the Seventh Circuit here sought to be reviewed, and the decision of the Court of Appeals for the Eighth Circuit in *North Little Rock Trans. Co.* v. *Casualty Reciprocal Exchange,* 181 Fed. (2) 174 (Cer. Den. 340 U. S. 823), holding that the McCarran Act barred a suit to enforce the provisions of the Sherman Act (otherwise clearly applicable) for acts done in the conduct of an insurance business which was regulated by the Arkansas law, and therefore, by virtue of the McCarran Act, subject to exclusive state jurisdiction.

The Parties.

Arcadia Mutual Casualty Company was organized in 1938 by Petitioner, Alfred Sylvanus, and a group of associates. Sylvanus had been general agent of Minnesota Mutual Life Insurance Company. His associates were mostly school teachers and had not been theretofore connected with the insurance business (R. 159).

On October 1, 1945, Arcadia Mutual Casualty Company combined with another company to form Arcadia Life & Casualty Company under Article XVI of the Illinois Insurance Code (R. 399-400). On December 1, 1946, the articles of incorporation of the last-named company were amended and the name was changed to Arcadia National Insurance Company, defendant and Petitioner here (R. 400, 401).

Alfred Sylvanus was president of each of the insurance companies mentioned (R. 170).

The Company always maintained the required reserves and its financial condition was uniformly approved in the reports of examination of the Illinois Insurance Department (R. 768, 773, 775-6, 790-1, 807, 825).

Petitioner, Voyle Clark Johnson, became connected with the other defendants through execution on February 24, 1944, of the agency contract with Arcadia Mutual Casualty Company, whereby he became agent for sales of the "Security" or limited coverage policy (R. 458-468). Johnson operated his agency under the name of "United States Insurance Agency."

The Alleged Scheme to Defraud.

The supposed "scheme to defraud" was alleged (R. 2-3) to have been to induce prospective policyholders to buy one or the other of two sickness or accident policies, known as the "Security Policy," offering limited coverage and

the "American Sentinel Policy," offering comprehensive coverage.

The policies are set forth at page 469 of the record and are summarized in Appendix 2, attached.

The premium on each policy was $1.00 per month, or $11.00 per year. With two exceptions, all the policies involved in this suit were of the Security Policy type.

The policies were advertised by circulars and published advertisements, each offering to submit the policy advertised for examination. The policies were issued only on application to the Insurance Company by the policyholder. There was no personal solicitation.

The device by which it is alleged the fraud was to be completed, comprised two elements:

(1) The circulation or publication of advertisements (each asking prospects to send for the policies for examination) which were alleged to emphasize maximum benefits payable but to omit reference to qualifying limitations and exceptions that might reduce the benefits or result in denial of claims on the policies; and

(2) The issuance of the policies, which (although approved by the State as to both form and substance) were alleged to have been "cunningly worded" and composed "in an ambiguous manner," and otherwise to have been arranged and worded so as to mislead the policyholders or prospects to whom they were tendered (R. 8-10, 172).

Of the 22 policyholders testifying, only 7 identified any advertising seen before purchase of the policy.

The charge of fraud rests primarily, therefore, on the alleged deceptive character of the state-approved policies. There is no contention that claims were not paid in accordance with the policy provisions, or that anyone profited by the supposed fraud. The evidence shows that the supporters of the enterprise were continually putting money

into it through purchase of guaranty certificates (payable only from earned surplus after reserves for policyholders had been fully provided for) so that the Company should be adequately financed (R. 825). No money was withdrawn to pay those certificates. They were never paid (R. 185).

When the conviction of the Petitioners in this case made it impracticable for the defendant Insurance Company to carry on its business, arrangements were made with another company to take over outstanding policy liabilities so that no policyholder would suffer any loss (R. 48).

The Insurance Policies and Advertising; the Comprehensive Nature of the Provisions of the State Law Relating Thereto; and the Supervision by State Authorities Under That Law.

The material provisions of the Illinois Insurance Code regulating the conduct of the insurance business in Illinois are set forth in Appendix 1, hereto attached.

Section 143, of the Illinois Code, relating to issuance of insurance policies of the class here involved, is as follows (Ch. 73, Ill. R. S. Par. 755):

> "(1) No company transacting the kind or kinds of business enumerated in Class 1 of section 4 shall issue or deliver in this State a policy or certificate of insurance, * * * or use an application blank, in this State until the form and content of such policy, certificate, * * * or application blank has been filed with and approved by the Director. *It shall be the duty of the Director to withhold approval of any such policy,* certificate * * * or application blank filed with him *if it violates any provisions of this Code, contains inconsistent, ambiguous or misleading clauses, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy.* In all other cases

the Director shall give his approval. Failure of the Director to act within thirty days after submission shall constitute approval. * * *"

[Italics are ours here and elsewhere unless otherwise stated.]

The insurance policies issued in the instant case (R. 469; summarized Appendix 2 attached) which were alleged to be so "cunningly worded" as to be in themselves a fraud (R. 8)—and upon which the conviction rests—were all submitted to and approved by the Illinois Insurance Department, as required by the above-quoted section of the state statute (R. 171-2). In fact, the original Security Policy issued in 1939 was drawn by an independent actuary from forms in use by other companies, as suggested by the Illinois Department of Insurance (R. 171).

Section 149 of the Illinois Insurance Code relating to advertising matter, reads as follows (Ch. 73, Ill. R. S. Par. 761):

"(1) No company * * * and no officer, director, agent, clerk or employee thereof * * * or any other person, shall make, issue or circulate * * * any * * * illustration, circular, or verbal or written statement of any sort misrepresenting the terms of any policy issued or to be issued by it or any other company or the benefits or advantages promised thereby * * *.

"(4) Any * * * person who violates any of the provisions of this section * * * shall be required to pay a penalty of not less than one hundred dollars, nor more than one thousand dollars. * * *."

All advertising matter circulated or published and here involved was subject to the foregoing statute, and if it was misleading, it was the duty of the state authorities so to find, and to prosecute the offenders for publishing it.

That the State Insurance Department was mindful of that duty is evidenced by its letter of November 27, 1940,

approving certain samples of advertising matter submitted, and concluding with the admonition that the Department was not "waiving any of its duties with respect to the enforcement of the provisions of the Illinois Insurance Code concerning advertising which misrepresents the terms of the policies advertised" (R. 764-5).

In many instances, the advertising matter thereafter circulated and published differed from the samples referred to in the last-mentioned letter from the State Department, in that the advertising did not characterize certain accidents for which benefits were payable as "public carrier accidents" or refer specifically to minimum as well as to maximum benefits payable.

The advertisements did, however, as suggested by the Illinois Insurance Department, refer the reader to the policies advertised for information as to specific limitations, and tendered the policies for examination before their final acceptance. Most of the so-called "puffing" statements to which objection was made in the course of the trial were in the circular letters approved (R. 760-764).

A detailed review of the advertising matter is not called for here. A summary of the advertising with particular reference to the comments thereon in the opinion of the Court of Appeals, is set forth in Appendix 3 attached.

Despite close supervision of the business for the entire period up to the return of the indictment, the State Department of Insurance made no complaint as to the advertising.

From 1941, through 1948, the Illinois Insurance Department made periodic examinations of the business of the defendant Insurance Company and of its predecessor companies, and filed exhaustive reports covering every phase of that business, with extensive comments and suggestions thereon (R. 767-842).

Notwithstanding the admitted duty of the Department of Insurance to review the advertising matter, there is no adverse comment thereon in any report. The last report, filed on November 22, 1948, after return of this indictment, comments favorably on the Company's reserves and operations and concludes with the statement that "policy claims appear to be paid promptly and in accordance with policy provisions" (R. 825).

It is thus a fair inference that the advertising matter, as well as the insurance policies, was approved by the State authorities. But whether approved or not, the advertising, as well as all other phases of the business, was admittedly subject to state supervision and control.

And even if the policies and advertising were misleading and fraudulent, the offense was one for the state authorities to pass on and to punish. Whether or not the Petitioners had issued deceptive policies or advertising and if so, what their punishment should be therefor, were for the state authorities to determine. The federal statute, and the penalty imposed thereby for the fraud committed, could not be substituted for the state statute, and for the penalty imposed thereby, without impairing and superseding the state statute.

If, as we contend, the McCarran Act should be construed to prohibit that result, then the judgment below cannot stand.

Questions of Federal Law Involved in Determining the Sufficiency of the Conspiracy Count.

The indictment has 18 counts. The first count charges that the three Petitioners jointly devised a scheme to defraud policyholders, or prospective policyholders by issuance of deceptive insurance policies and advertising matter and in execution of the scheme, Petitioners sent or received

through the mails a communication to or from the supposed victim. Each of the next 16 counts adopts the allegations of the first count as to the scheme and alleges a different mailing (R. 2-16).

The 18th Count also adopts the first count by reference and charges that the joinder between the parties to devise the scheme is also a conspiracy separately punishable (R. 16-19).

The indictment was returned on September 10, 1948. Fifteen so-called overt acts are charged, all of which, except the last four, were committed more than three years before the return of the indictment. The supposed overt acts referred to (R. 17-19) are thus summarized:

(1-2) On October 14, 1938, the incorporation of Arcadia Mutual Casualty Company and election of Sylvanus as director.

(3) On October 14, 1940, approval by the State of the Security Policy, Form L-102.

(4) On May 1, 1942, opening of insurance company office at 221 North La Salle Street, Chicago.

(5) On December 18, 1943, purchase of $1,091 in guaranty fund certificates by defendant Voyle Clark Johnson.

(6) On December 18, 1943, purchase of $860 in guaranty fund certificates by defendant Sylvanus.

(7-8) On February 24, 1944, execution of agency contract with defendant Johnson and receipt of premiums by him thereafter.

(9-11) On December 29, 1944, and again on March 29, 1945, and again on April 23, 1945, the purchase by Johnson of guaranty fund certificates, totaling $19,909.

(12) On October 1, 1945, incorporation of Arcadia Life and Casualty Company by Sylvanus.

(13) On October 1, 1945, election of Sylvanus as a director in that company.

(14) On January 1, 1947, incorporation of defendant Arcadia National Insurance Company.

(15) On January 1, 1947, election of Sylvanus as a director in that company.

None of the alleged overt acts is sufficient to support a conspiracy charge, because none commits the supposed conspirator to the criminal act alleged to have been contemplated. But if the 3-year statute of limitations applies, none but the last four acts could be considered in any event, and each of them is insufficient to constitute an "overt act".

The Court of Appeals held, citing *U. S.* v. *Cohen*, 145 Fed. 2d 82 (CCA 2) that the Statute of Limitations did not bar prosecution on the Conspiracy Count, even if there was no allegation of a sufficient overt act occurring within 3 years before the indictment (R. 931).

That holding is contrary to the decision of this Court in *Fiswick* v. *U. S.*, 329 U. S. 211 (216-7).

The decision of this question is important because the Judge charged the jury that if a conspiracy was established and the jury found "beyond any reasonable doubt that any of the overt acts described in the indictment took place either prior to or during said defendants' connection with the conspiracy" the jury must find the defendants guilty (R. 371).

A separate motion was made to dismiss the conspiracy count (R. 155, 269-270) so that the point was properly raised.

The Basis on Which the Jurisdiction of This Court Rests.

The jurisdiction of the Supreme Court of the United States in this case is derived from Section 1254 (a), Title 28, U. S. Code, conferring jurisdiction on this Court to

issue writs of certiorari to review decisions of the United States Courts of Appeal.

The decision sought to be reviewed rests wholly on federal law, and the questions raised are as to the correct construction of the federal statutes involved.

Statements of the questions presented and of the reasons why writ of certiorari should be issued are set forth in the next two subdivisions of this petition.

The Questions Presented.

1. The first question presented is whether or not, under a correct construction and application of the McCarran Act (Sec. 1011-1015, Title 15, U. S. C.) this prosecution under the Acts of Congress, relating to mail frauds and conspiracies (Secs. 1341 and 371, formerly Secs. 338 and 88, Title 18, U. S. C.) can be maintained, in view of the fact that the fraudulent scheme charged involves only the issuance of insurance policies and the circulation of advertising matter in the conduct of an insurance business regulated by Illinois law.

As a corollary, a question is raised as to which of the following conflicting decisions as to construction and application of the McCarran Act is correct:

(a) The decision of the Court of Appeals for the Seventh Circuit (R. 920-1), in the instant case, holding that the McCarran Act does not remove from purview of a general federal statute (in this case the statute relating to mail fraud and conspiracy) passed pursuant to constitutional authority, acts performed in the conduct of a state-regulated insurance business; **or**

(b) The contrary decision of the Court of Appeals for the Eighth Circuit in *North Little Rock Trans. Co.* v. *Casualty Reciprocal Exchange,* 181 Fed. (2) 174 (Cer. Den. 340 U. S. 823) holding that the McCarran Act was a bar to a suit to enforce the penal

provisions of a general federal statute (in that case the Sherman Act—also passed purusant to constitutional authority) for acts in the conduct of an insurance business that would otherwise have been a violation of that Act.

The question as to the construction and application of the McCarran Act was raised in the District Court by motion to strike the indictment (R. 25) and by motions for acquittal at the close of the Government's evidence and at the close of all the evidence (R. 155-7; 269-70); and in the Court of Appeals on appeal from the judgment of conviction (R. 876).

2. The second question involved is as to whether or not, under a correct construction of the federal statute, relating to conspiracies, (Sec. 371, formerly Sec. 88, Title 18, U. S. C.) and of the applicable statute of limitations (Sec. 3282, Title 15, U. S. C.), the alleged overt acts set forth in the conspiracy count are sufficient to sustain a prosecution under that statute. This question was raised in the District Court on the motion to dismiss the conspiracy count at the close of the Government's evidence (R. 155) and at the close of all the evidence (R. 270) on the ground that a conspiracy was not shown.

3. The third question raised is as to which of the following conflicting decisions is correct:

(a) The decision of the Court of Appeals for the Seventh Circuit in the instant case (R. 936) that it is not the duty of an insured to read his policy in order to ascertain the conditions contained therein, even though the advertising complained of tenders the policy to him for examination before acceptance, and refers to the policy for the specific limitations and conditions affecting the insurance; or

(b) The decision of the Court of Appeals for the District of Columbia in *Bowers* v. *Washington Times Co.*, 65 Fed. (2) 200, applying a contrary principle in a civil suit to recover the maximum benefit advertised.

The question as to the duty of the insured to read his policy and as to the extent to which he was bound by the policy provisions was raised on motions for acquittal at the close of the Government's evidence and at the close of all the evidence (R. 155-7; 269-70), and also by instruction tendered and refused that it is the duty of the insured to read his policy of insurance, to ascertain the conditions therein contained, and if such policy is unsatisfactory, to object thereto at the time (R. 273).

The question was raised in the Court of Appeals on appeal from the judgment of conviction (R. 876-7; 883).

Reasons Relied on for Allowance of the Writ of Certiorari.

We submit that a writ of certiorari should be granted in this case for the following reasons:

1. *The Question of Construction of the McCarran Act.*

The decision of the Court of Appeals rests on a construction of the McCarran Act. The opinion admits that the right to determine what policies may be issued, what advertising may be published and circulated, whether or not the policies or advertising are misleading, and what the punishment shall be if they are misleading, are all exclusively with the state (R. 920-1).

The Court holds, however, that if coupled with the issuance of the policies and advertising, there is a use of the mails, the Federal Court may determine independently and without regard to state jurisdiction whether or not the policies and advertising are fraudulent and whether or not the issuer thereof should be punished (R. 921).

The reason give by the Court is that Congress has power under the Constitution to regulate the mails, and hence a statute enacted in exercise of that power should not be limited in its operation because of jurisdiction of the state over the subject matter of the fraud (R. 921).

The reason stated ignores both the wording and the intent of the McCarran Act.

Every valid act of Congress is passed in the exercise of some Constitutional power. If Congress so desires, it may extend that power over the conduct of a state-regulated insurance business. But the McCarran Act declares, that unless Congress, in a statute exercising its consti-

tutional power, sets forth that the statute shall apply to the conduct of an insurance business, it will not be extended to that business.

The title of the McCarran Act is "*An act to express the intent of Congress with reference to the regulation of the business of insurance.*" The inention expressed is that the regulation shall be left wholly to the states, and thus to except from the purview of any federal statute not made expressly applicable to the insurance business, all matters pertaining to the conduct of that business that are subject to state regulation.

The statute relating to mail frauds does not, by its terms, apply to the acts performed in the conduct of an insurance business, and hence under a literal construction of the McCarran Act, could not be construed to cover those acts.

In holding to the contrary, the Court of Appeals held, in effect, that, despite the McCarran Act no one carrying on an insurance business can rely on the state law regulating that business, or on the directives of the state authorities acting thereunder, for determination of what policies or advertising he may issue or circulate.

The question of federal law raised is important and has not been determined by this Court. It is in the public interest that it be determined.

2. *Conflict Between the Decision in the Instant Case and the Decision of the Court of Appeals for the Eighth Circuit Construing the McCarran Act.*

The construction of the McCarran Act in the instant case is based on a principle contrary to that on which the decision was based in *North Little Rock Transp. Co.* v. *Casualty Reciprocal Exchange,* 181 Fed. (2) 174. In that case, North Little Rock Transportation Co. sued the Casualty Reciprocal Exchange for triple damages under the Sher-

man Act. The defendants had clearly engaged in a combination in restraint of interstate commerce within the meaning of the Sherman Act and the principle laid down in *U. S.* v. *Southeastern Underwriters Assn.*, 322 U. S. 533, holding insurance to be interstate commerce.

The defense was that the conduct complained of was regulated by the laws of Arkansas, "and that because of the Act of March 9, 1945 * * * 15 U. S. C. A. Secs. 1011-1015, known as the McCarran Act, the Sherman Act did not apply to the insurance business so far as it is regulated by the state."

In sustaining that defense, the Court said (181 Fed. (2d), at p. 176):

> "The purpose of the McCarran Act was to permit the States to continue the regulation of the business of insurance, unhampered, to the extent provided by the Act, by federal legislation relating to interstate commerce."

The same principle would apply to "federal legislation" relating to use of the mails. But the Court of Appeals for the Seventh Circuit refused to follow that principle here.

There is, therefore, a conflict between the decision of the Circuit Court of Appeals in the instant case and the decision of the Eighth Circuit Court of Appeals in the *North Little Rock Transportation Co.* case, on substantially the same question of construction of the McCarran Act, and for that reason, this Court should grant the writ.

This is another reason for granting a writ of certiorari.

As the Court said in *Jerome* v. *U. S.*, 318 U. S. 101 (102) in stating the reason for granting a writ where the question was whether the word "felony" as used in Act of Congress applied to a State, as well as to a federal offense:

> "We granted a petition for a writ of certiorari because of the importance of the problem in the administration of justice and because of the diversity of views

which have developed as respects the meaning of felony."

3. *Question of Construction of the Statute Relating to Conspiracies as to Sufficiency of the Overt Acts Charged and the Application of the Statute of Limitations Thereto.*

This question has been fully stated at pages 11-13 and 15, *ante*. We contend that none of the overt acts is sufficient to commit the actor to the perpetration of the contemplated crime of using the mails to execute the fraudulent scheme so that he could not withdraw and be innocent. And this is particularly true if only the acts within the three-year period prior to the indictment are considered.

In view of the tendency to use the conspiracy statute as a means of charging the same offense a second time, and of relieving the prosecution from the necessity of adhering to rules of evidence in proving it, the question raised is important and should be passed upon.

4. *The Conflict in the Decisions of the Circuit Courts of Appeals With Respect to the Obligation of a Policyholder to Read His Policy in Order to Determine the Conditions and Limitations Thereof.*

This question is also stated at pages 15-16, *ante*.

The opinion of the Court of Appeals in the case at bar holds that there is no conflict in principle between this case and *Bowers* v. *Washington Times*, 65 Fed. (2) 200, decided by the Court of Appeals for the District of Columbia, because, as the opinion states, the last-mentioned case was a civil case (R. 936).

The distinction is not sound because in both cases the question was whether the prospective policyholder can rely on the advertising to the exclusion of the policy, notwithstanding the fact that the advertising refers the reader to the policy for a specific statement of the limitations and conditions attached to payment of the risk. The adver-

tising in the *Washington Times* case was similar to that most complained of in the instant case, in that it stated the maximum benefit payable without stating the limitations and conditions under which the policyholder would receive it, and thus left the policyholder to read the policy itself for determination of what those limitations were. The decision in the *Washington Times* case that the policyholder was bound by the policy, at least insofar as it was supplementary to and not in conflict with the advertising (which was true in every instance in the case at bar) was based on a principle exactly contrary to that applied here, where the jury was instructed that a policyholder was not even required to read his policy.

The conflict in decisions on this point is an additional reason why this Court should grant this petition for a writ of certiorari.

For the reasons above stated Petitioners pray that a writ of certiorari be issued by this Court for review of the judgments entered in this case on December 1, 1951, by the Court of Appeals for the Seventh Circuit.

ALFRED SYLVANUS, ARCADIA NATIONAL INSURANCE COMPANY, and VOYLE CLARK JOHNSON,

Petitioners,

By ROGER SHERMAN,
HENRY F. TENNEY,
S. ASHLEY GUTHRIE,
Attorneys for Petitioners.

S. ASHLEY GUTHRIE,
Of Counsel.

BRIEF IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI.

The opinion of the Court of Appeals is not yet reported. It is set forth in full at pages 919 to 937 of the Record.

The jurisdiction of this Court is invoked under Section 1254(a), Title 28, United States Code, conferring jurisdiction on this Court to issue writs of certiorari to review decisions of the United States Circuit Court of Appeals.

The essential points of the case have been sufficiently stated in the foregoing petition for writ of certiorari and in the appendices hereto.

Specification of Errors.

We rely here on the following assignment of error:

1. The Court of Appeals erred in sustaining the action of the trial Court in overruling the defendants' motion to dismiss the indictment, made on the following ground: The conduct of the insurance business in Illinois, is regulated exclusively by state law. Under the McCarran Act (Secs. 1011-1015, Title 15, U. S. Code), the laws of Congress on which this prosecution is based, do not apply to the acts alleged in the indictment. (R. 25.)

2. The Court of Appeals erred in sustaining the action of the trial Court in not granting defendants' motions for acquittal at the end of the Government's evidence and at the end of all the evidence. The motions should have been granted because:

(a) The evidence did not show that the defendants had any fraudulent or criminal intent.

(b) The insurance policies complained of are not ambiguous or misleading. They were prepared by an independent actuary and are in form and substance as specified and approved under the Illinois law.

(c) The advertisements published or circulated in connection with the issuance of the policies did not make the issuance of the policies fraudulent. The advertisements were substantially in form approved by the State Department of Insurance, but in any event they did not misstate any material fact. They tendered and referred to the policies for the specific provisions thereof with promise of refund if the policies were unsatisfactory.

3. The evidence does not sustain the conviction of any of the defendants for the conspiracy charged in the eighteenth count and the separate motions to dismiss or for acquittal on that count made at the close of the Government's evidence, and at the close of all the evidence should have been granted, because:

(a) The "conspiracy" set forth in the eighteenth count is the same as the "scheme to defraud" set forth in the earlier counts. The conspiracy count cannot stand, if the other counts fall.

(b) The overt acts charged and relied on do not bear any proximate relation to attainment of the object of the conspiracy and do not sustain conviction on the conspiracy count.

4. The Court of Appeals erred in sustaining the ruling of the trial Court that a prospective policyholder was not required to read his policy to determine the terms and conditions thereof, and was not bound by what the policy would have disclosed by reading it, and in refusing a tendered instruction to the jury to that effect.

I.

THE MOTION TO DISMISS THE INDICTMENT SHOULD HAVE BEEN SUSTAINED BECAUSE THIS PROSECUTION IS BARRED BY THE McCARRAN ACT.

A.

THE SCHEME TO DEFRAUD, CHARGED IN THE INDICTMENT, INVOLVES ONLY THE ISSUANCE OF INSURANCE POLICIES AND ADVERTISING MATTER SUBJECT TO REGULATIONS IMPOSED BY STATE LAW; UNDER THE McCARRAN ACT THE MAIL FRAUD STATUTE CANNOT BE CONSTRUED TO COVER THAT SCHEME, BECAUSE, IF SO CONSTRUED, IT WOULD INVALIDATE, IMPAIR, OR SUPERSEDE THE STATE LAW.

The ground on which the Court holds that the McCarran Act does not bar this prosecution is thus stated in the opinion (R. 921):

> "* * * it cannot be properly said that this indictment has to do with the regulation of insurance business in Illinois. Rather it has to do with the question of whether defendants have used the mails in pursuance *of a scheme so to manipulate their authorized regulated business in Illinois as to result in fraudulent deception of its prospective policy holders. The charge* is not that the corporate charter should be ignored or that the administrative officers of Illinois may not perform their statutory duties and supervise and regulate the company's insurance business in Illinois, but *goes to the use of the mails, over which the Congress has, by the Constitution, paramount power and authority.*" (Italics are ours here and elsewhere unless otherwise stated)

We submit that the ground stated is not sound, and that the decision based on it should not be adhered to.

It is true that Congress has power to control the mails, and may exercise that power along with other constitutional powers, so as to control a state-regulated insurance business, provided Congress expressly elects to do so. But Congress, by the McCarran Act (Title 15, Sec. 1011-2, U. S. Code, Mar. 9, 1945) has elected not to do so. Instead, it has provided that a general statute shall not be extended to apply to a state-regulated insurance business, unless the intention so to extend it is specifically set forth in the statute.

The McCarran Act provides:

(1) That "the continued regulation and taxation by the several states of the business of insurance is in the public interest, * * *;"

(2) That "the business of insurance and every person engaged therein shall be subject to the laws of the several states"; and

(3) That "no act of Congress shall be construed to invalidate, impair or supersede any law enacted by any state for the purpose of regulating the business of insurance, * * * unless such Act specifically relates to the business of insurance: * * *"

The McCarran Act thus creates an exception to every general statute theretofore or thereafter passed by Congress (whether in exercise of its power to control the mails, or in the exercise of its power to control interstate commerce, as in the Sherman Act, or in the exercise of any other power), removing from the purview of such

statute all matters pertaining to the conduct of a state-regulated insurance business, unless the intent that the statute shall apply to that business is expressly stated therein.

The words, *"invalidate," "impair,"* and *"supersede,"* are thus defined in Webster's Dictionary:

> *Invalidate*—to render invalid or null; to weaken or destroy the force of.
>
> *Impair*—* * * to diminish in quantity, value or strength.
>
> *Supersede*—to cause to be set aside, forced out of use * * * to take the place, room, or position of; to replace.

By use of the three words, the McCarran Act provided that no federal statute (unless stated to be applicable to the insurance business) should be extended in its application so as to weaken, or lessen the value of, or take the place of, any provision of "any law enacted by any state for the purpose of regulating the business of insurance."

The Illinois Insurance Code is a state law enacted "for the purpose of regulating the business of insurance," and is directly within the exception created by the McCarran Act to the application of all general federal statutes.

The Illinois Code requires policies and advertising to conform to specified standards, and provides penalties for non-conformance with those standards. The pertinent provisions of the Code are set forth in Appendix 1, attached hereto.

Section 143 of the Illinois Insurance Code (Ch. 73, Ill. R. S., Par. 967), prohibiting the issuance of any policy not approved by the State Insurance Department, or containing any misleading statement or unfair condition, and Section 149 of the Code (Ch. 73, Ill. R. S., Par. 761) pro-

hibiting circulation of misleading advertising and providing penalties therefor, are set forth at pages 8 and 9, *ante*.

Section 401 (Ch. 73, Ill. R. S., Par. 1013) provides for supervision and periodic examinations of the conduct of the business by the Director of Insurance; and Section 446 (Ch. 73, Ill. R. S., Par. 1058) provides penalties for any violation of the law for which no other specific penalty is provided in the Code.

The statute relating to mail frauds cannot, under the McCarran Act, be extended so as to weaken the force of, or to render inapplicable, or to take the place of, any of the foregoing regulations of The Illinois Insurance Code with respect to policies and advertising, and with respect to the penalties prescribed for violation of those regulations.

This is so, whether or not the Illinois law has been violated or whether or not the Federal Court deems the penalty prescribed by the state law to be inadequate.

If the Illinois law has not been violated, then a conviction under the federal statute would result in substitution of the federal regulation for the state regulation and in the imposition of a punishment by the Federal Court for acts that are authorized under the state law. And if the Illinois law has been violated, such conviction would result in an imposition of a federal penalty for the violation, in place of or in addition to the state penalty, and would constitute a like assertion by the Federal Court of jurisdiction over a transaction which the McCarran Act declares, as a matter of public policy, is left wholly to the control and jurisdiction of the states. In either event, the force of the Illinois law, relating to the conduct of an insurance business, is destroyed and that law is impaired and superseded by the federal statute.

B.

A Conviction Under the Mail Fraud Statute Necessarily Involves An Assumption of Federal Jurisdiction Over the Conduct of An Insurance Business in Illinois, and Thus Renders Ineffective the Regulations Imposed by State Law Relating Thereto.

It is said, in answer to the foregoing argument, that the conviction under the federal statute is for use of the mails and not for the fraudulent scheme.

That is not true under any fair analysis of the issues.

The crime defined in the mail fraud statute comprises two elements: (1) the devising of "a scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent promises"; and (2) the use of the mails to execute the scheme (Sec. 1341, formerly Sec. 338, Title 18, U. S. C.).

While it has been said that the use of the mails is "the gist of the offense," in the sense that it gives the Federal Court jurisdiction, the scheme or artifice to defraud is the essential element, the very basis of the crime.

As said by the Court of Appeals for the Seventh Circuit, in *Worthington* v. *U. S.*, 64 Fed. (2) 936 (941):

> "In a mail fraud action such as the one we are considering, a fraudulent scheme is an essential element of the crime. While federal authority is exercised because of the use of the mails by the wrongdoer, the wrong—namely, the fraudulent scheme—is an essential and often is the only controverted issue involved."

The scheme to defraud, charged in the indictment, consists of (1) the issuance of insurance policies alleged to have been "composed in an ambiguous and confusing manner" and to be "cunningly worded, arranged and set up,"

so as to be in themselves misleading and fraudulent; and (2) the circulation of misleading advertisements with respect to those policies (R. 5-10).

In order to sustain a conviction on any of the substantive counts, or on the conspiracy count, the indictment must charge, and the evidence must prove, the existence of this fraudulent scheme, namely, that the policies and the advertising relating to them, issued or contemplated, were fraudulent and misleading. Otherwise there would be no scheme to defraud that could be executed by the use of the mails or with respect to which any conspiracy could exist.

The question as to whether a fraudulent scheme was charged and proved was the principal issue in this case. It is the issue to which all the evidence, argument and the review on appeal were directed. If (because of the McCarran Act) the mail fraud statute does not extend to that scheme, the indictment does not state a case.

The opinion of the Court of Appeals cites *Badders* v. *U. S.*, 240 U. S. 391 and *O'Hara* v. *U. S.*, 129 Fed. 551 (C. A. 6), on the proposition that a prosecution under the mail fraud statute may be maintained even though the scheme charged relates to transactions regulated or forbidden by state law (R. 921).

Neither case is in point.

There is no question but that (in the absence of a statute like the McCarran Act taking the transaction in question out of the purview of general federal statutes) one may be punished under the federal law for performing an act in a transaction that is also subject to state law, and for which he may also be punished under the state law.

But it has long been recognized that it is contrary to sound public policy to extend a federal statute to matters

primarily subject to state jurisdiction, if such construction of the federal statute can be avoided.

Jerome v. *U. S.*, 318 U. S. 101 (105).

And in *Hendrey* v. *U. S.*, 233 Fed. 5 (7-8) (C. C. A. 6), decided by the same Court that decided the *O'Hara* case, the Court reluctantly held that the fact that the alleged fraudulent scheme was subject to regulation by, and was an offense punishable under, the state banking laws, was not a defense against a prosecution under the mail fraud statute. The Court stated that the liability to double punishment might well be against sound public policy, but that only Congress could remedy that situation. As to this, the Court said (pp. 7-8):

> "* * * the practical effect of this situation is to call upon the laws or courts of the United States to punish citizens of a state for violating the laws of that state * * *. If it be true, as it is sometimes thought, that there was no deliberate intent to extend so far the federal criminal jurisdiction, *restriction can come only from Congress.*"

The McCarran Act supplies the restriction from Congress suggested in the above quotation, necessary to prevent conviction under a general federal statute for acts in the conduct of an insurance business subject to state law, and for which the action is punishable under the state law if any intent to mislead or defraud a prospective policy holder is shown. As Congress declares in the McCarran Act, "it is in the public interest" to leave the control of the insurance business to the states.

If the Illinois law is not severe enough, that gives no right to the federal court to interfere. It is a matter to be addressed to the legislature for correction.

C.

THE McCARRAN ACT IS NOT RESTRICTED IN ITS OPERATION TO STATUTES PASSED UNDER THE COMMERCE CLAUSE; BY ITS TERMS IT EXCLUDES FROM APPLICATION OF ALL ACTS OF CONGRESS (NOT EXPRESSLY RELATING TO INSURANCE) MATTERS CONNECTED WITH A STATE-REGULATED INSURANCE BUSINESS.

It was argued by the Government in the District Court that the "Acts of Congress" which the McCarran Act declares shall not apply to the insurance business are intended to include only Acts of Congress enacted under the commerce clause of the Constitution.

There is no warrant in the statute for such restrictive interpretation.

The necessity for legislation to prevent federal control of the insurance business became apparent when this Court held, in *U. S.* v. *Southeastern Underwriters*, 322 U. S. 533, that transactions across State lines in the conduct of an insurance business were interstate commerce and were therefore subject to the criminal provisions of the Sherman Act, even though the conduct of the business was subject to state regulation and control.

The effect of the McCarran Act was to remove from the purview of both the criminal and civil provisions of the Sherman Act, all transactions connected with a state-regulated insurance business; but the McCarran Act was not limited in its application to the Sherman Act, or other acts passed under the commerce clause.

An act of Congress passed under a constitutional grant of authority to regulate the mails, or under any other constitutional grant, may interfere with the conduct of an insurance business to the same extent as an act of Congress passed under constitutional grant of authority to regulate interstate commerce. A criminal prosecution un-

der the mail fraud statute is as effective in nullifying and superseding the state law as is a similar prosecution under the Sherman Act.

The statutory language is clear and it is neither necessary nor proper to go into the legislative history or to the debates in Congress to determine its meaning or to engraft on the act a purpose or restriction not expressed in it.

> "The short answer is that there is no need to refer to the legislative history where the statutory language is clear."
>
> *Ex Parte Collett,* 337 U. S. 55 (61).

See also *Helvering* v. *City Bank Farmers Tr. Co.,* 296 U. S. 85 (89).

The legislative history, however, supports the conclusion that the McCarran Act is intended to prevent interference of all acts of Congress with state regulation of the insurance business.

As stated by the House Committee on Judiciary in its report recommending passage of the bill:

> "Already many insurance companies have refused, * * * to comply with * * * State regulations, on the ground that to do so, when such laws may subsequently be held unconstitutional in keeping with the precedent-smashing decision in the *Southeastern Underwriters* case, will subject insurance executives to both civil and criminal prosecutions * * *.
>
> The committee has therefore given immediate consideration to S. 340, together with a similar measure, H. R. 1973, so that the several States may know that Congress desires to protect the continued regulation and taxation of the business of insurance by the several States, and thus enables insurance companies to comply with State laws." U. S. Code Congressional Service, 1945, p. 671.

There is nothing in the report indicating an intent to restrict the meaning of "Acts of Congress," which Section 1012 declares are not to interfere with state insurance regulations, to Acts of Congress enacted under the commerce clause.

The McCarran Act made no distinction, but provided that "*no Act of Congress*" (unless it expressly relates to insurance) should be extended so as to apply directly or indirectly to any transaction involved in the conduct of a state-regulated insurance business.

D.

The Question of Federal Law Involved in Construction of the McCarran Act Has Not Been, But Should Be, Decided by This Court; and the Conflict Between the Decisions of the Circuit Courts of Appeal Should Be Resolved.

The McCarran Act first came before this Court for construction in *Prudential Insurance Co.* v. *Benjamin*, 328 U. S. 408 in which the Prudential Insurance Company attacked the validity of a South Carolina statute regulating the conduct of the business of insurance and imposing a tax on this business in South Carolina, even though the transaction extended across state lines. The Court sustained the South Carolina statute; held the McCarran Act constitutional; and further held that the effect of the act was to confer power on the state to regulate and tax insurance transactions even though interstate in character.

The only other case involving construction of the McCarran Act, here important, is *North Little Rock Trans. Co.* v. *Casualty Reciprocal Exchange*, 181 Fed. (2) 174, abstracted at pages 18-19, *ante*. In that case, the Court held the McCarran Act was effective to remove insurance transactions from the purview of the Sherman Act and

to bar a suit under that act for treble damages for injury done to the plaintiff by combination between insurance underwriters permitted under the state law.

The question at issue in the last-cited case is not essentially different from that in the case a bar—if we substitute "mail fraud statute" for the "Sherman Act." But the decisions are exactly contrary.

The decision in the *North Little Rock Trans.* case is more in line with the principles applied by this Court in construing similar statutes.

Thus in *Connecticut Light and Power Co.* v. *Federal Power Commission,* 324 U. S. 515, this Court reversed a decision of the Court of Appeals holding accounting practices of the defendant utility subject to the jurisdiction of the Federal Power Commission, despite a statutory exemption of State regulated utilities from the Act there in question. As to this, the Court said (pp. 528, 532):

> "It is hard for us to believe that Congress meant us to read 'shall have jurisdiction' where it had carefully written 'but shall not have jurisdiction.' The command 'thou shalt not' is usually rendered as to forbid and we think here it was employed without subtlety or contortion and in its usual sense. * * * 'Where a federal agency is authorized to invoke an overriding federal power except in certain prescribed situations and then to leave the problem to traditional state control, the existence of federal authority to act should appear affirmatively and not rest on inference alone'."

And see also:

> *Panhandle Eastern Pipeline Company* v. *Public Service Commission,* 332 U. S. 507.

We submit that the question as to the construction of the McCarran Act should be passed upon by this Court;

that under a proper construction of that act the issuance or contemplated issuance of insurance policies and advertising matter, charged in the indictment to comprise a fraudulent scheme, are excluded from the purview of the statutes relating to mail frauds and conspiracies; and hence that the motion to dismiss the indictment should have been sustained.

It follows that the motions for acquittal should also have been granted because of the insufficiency of the indictment and because approval by state authorities of the policies issued is conclusive, that their issuance was not contrary to public policy and that they were neither unfair nor deceptive.

II.

NONE OF THE SUPPOSED OVERT ACTS SET FORTH IN THE CONSPIRACY COUNT IS SUFFICIENT TO SUSTAIN THE CHARGE OF CONSPIRACY AND THE MOTIONS TO DISMISS OR FOR ACQUITTAL ON THAT COUNT SHOULD HAVE BEEN GRANTED.

The act relating to conspiracies require, as a necessary element of the offense, that one of the parties to the conspiracy "do any [an] act to effect the object of the conspiracy." (Sec. 371, Title 18, U. S. C.)

The purpose of the requirement of an overt act is thus stated:

> "The provision of the statute, that there must be an act done to effect the object of the conspiracy, merely affords a *locus poenitentiae*, so that before the act is done either one or all of the parties may abandon their design, and thus avoid the penalty prescribed by the statute."
>
> *U. S.* v. *Britton*, 108 U. S. 199 (204-5).

The overt act must be some positive, active step "to effect the object of the conspiracy."

U. S. v. *McLaughlin,* 169 Fed. 302 (307) (D. C. D., Minn.).

In practice, the only overt act that could so tend to *reflect* the design to use the mails, is an actual use of the mails. Hence, it is almost invariably a use of the mails that is charged as an overt act in a count for conspiracy to use the mails to defraud. For example, see *Hendrey* v. *U. S.,* 233 Fed. 5 (12) C. A. 6); *Brady* v. *U. S.,* 24 Fed. (2) 399 (404-5) (C. A. 8).

The acts charged in the indictment here to be "overt acts" (R. 17-18) are set forth at pages 12-13, *ante.* They may be thus summarized:

Acts performed more than 3 years prior to the indictment:

1-4: The organization of Arcadia Mutual Casualty Company; the appointment of Sylvanus as director; the procuring of authorization to do business; and the establishment of an office to do business.

5-11: The entry of the company into the insurance business; the appointment of Johnson as agent; the receipt of premiums; and the making of subscriptions to the guaranty fund required by statute to finance the business.

Acts performed less than 3 years prior to the indictment:

12-15: The organization of the successor insurance companies and the appointment of Sylvanus as officer and director.

None of the acts referred to could be classed as an irrevocable step toward commission of the crime of using the mails to defraud.

But in any event, only the last four acts charged are within the three-year limitation period (Sec. 3282, Title 18, U. S. C.) and since they are insufficient, the entire count falls.

Fiswick v. *United States*, 329 U. S. 211 (216-7).

The decision by the Court of Appeals in the instant case (R. 931) that the three-year limitation does not apply, is in conflict with the decision in the *Fiswick* case last cited.

The question was raised on separate motions for judgment on the conspiracy count (R. 155, 269-270). The motions were overruled and the District Judge instructed the jury that if they found that the defendants (Petitioners) committed any of the acts charged, the jury should convict them (R. 371).

The conspiracy charged in the 18th Count is hardly distinguishable from the substantive offense charged in each of the other counts.

The use of a loose conspiracy count to relieve the prosecutor from restrictions imposed by the hearsay rule and thus to procure a conviction, has been strongly condemned as a threat to the fair administration of justice.

Krulewitch v. *United States*, 336 U. S. 440 (445-6).
U. S. v. *Rosenblum*, 176 Fed. (2) 321 (332) (C. C. A. 7).

We submit that the Court should pass on the question here raised and that the conspiracy count cannot stand.

If that count and the evidence offered under it had been excluded, the case presented would have been essentially different, and there may have been no conviction on the other counts.

III.

THE DISTRICT COURT AND THE COURT OF APPEALS SHOULD HAVE HELD THAT IT WAS THE DUTY OF THE INSURED TO READ HIS POLICY IN ORDER TO ASCERTAIN THE CONDITIONS CONTAINED THEREIN, AND THE JURORS SHOULD HAVE BEEN INSTRUCTED ACCORDINGLY.

The Government's fundamental objection to the circular letters and advertisements is that they state maximum benefits without setting forth the conditions and limitations that may reduce those benefits or affect the risks covered.

But the advertisements or letters do not purport to include all terms of the policies. The reader is referred to the policy for specification and amplification. The applicant is bound by the limitations in the policy, and if the policy fairly states them, there is no fraud.

Thus, in *Bowers* v. *Washington Times Co.*, 65 Fed. (2) 200 (C. A. D. C.), the advertisement read as follows:

> "One dollar provides protection for $10,000 to subscribers of the Washington Times. * * * For loss of life, $10,000. For loss of both eyes, $10,000. * * * With other provisions."

The policy provided (as does the Security policy here) that the maximum benefit (in that case $10,000) was to be paid on the insured's death only if caused by wrecking of a railroad passenger car, steamship, ferry, street car, elevated or subway car. Otherwise the indemnity for death would be $500.

The insured was killed in an automobile accident. The Court held that his beneficiary could recover only $500

and that there was no fraud in the advertising or in the policy. The Court said (p. 202):

> "The advertisement sets out in a prominent manner that the policy in question would contain other provisions. The insured was thereby notified that he should examine the policy in order to fully acquaint himself with its terms.
>
> It appears that the policy which was tendered to appellant after the death of decedent was of the standard type and form issued by the defendants in such transactions and referred to in the receipt which decedent received in his lifetime. There was no fraud or concealment in the character of the policy, such as to mislead any reasonably careful person."

The Court of Appeals in its opinion, in the instant case, refused to follow *Bowers* v. *Washington Times Co.* on the ground that that was a civil case (R. 936).

The distinction is not valid.

The suit in the *Bowers* case was not for recovery on the policy, but for recovery of the $10,000 indemnity advertised, which was greater than the amount payable in the policy for the particular loss sustained. The plaintiff denied (as here) that the insured did not have to read his policy, but could rely on the advertising. The suit was based on a fraud rather than on a contract. The question involved is the same as that involved in the case at bar, and the two decisions cannot be reconciled.

In view of the fact that the policies here had been approved by the State Department of Insurance, which had sole jurisdiction over them, it cannot be properly contended that they are deceptive or misleading or that their issuance showed the actual intent to defraud, that is essential to a conviction.

Reilly v. *Pinkus*, 338 U. S. 269 (276).

The question presented is important, and the Court

should resolve the difference between the decisions thereon by the Court of Appeals for the 7th Circuit in this case, and by the Court of Appeals for the District of Columbia in *Bowers* v. *Washington Times Co.*

If this question is resolved in favor of the Court of Appeals of the District of Columbia, it follows that the District Court erred in the instant case in not granting the motion for acquittal and in any event, in refusing to give to the jury the tendered instruction stating that it was the duty of the insured to read his policy and if it was unsatisfactory, to reject it (R. 273).

We submit that the Court should grant a writ of certiorari in this case and that the decision of the Court of Appeals herein should be reversed.

Respectfully submitted,

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APPENDICES.

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APPENDIX 1.

EXCERPTS FROM ILLINOIS INSURANCE CODE OF 1937 (Ch. 73, Ill. R. S.).

"ARTICLE I * * * CLASSIFICATIONS.

* * * * *

Sec. 4 [Ch. 73, Ill. R. S., Par. 616] **Classes of Insurance.**

Insurance and insurance business shall be classified as follows:

Class 1. Life, Accident, and Health.

* * * * *

(b) Accident and Health. Insurance against bodily injury, disablement or death by accident and against disablement resulting from sickness or old age and every insurance appertaining thereto."

"ARTICLE IX—PROVISIONS APPLICABLE TO ALL COMPANIES.

Sec. 132 [Ch. 73, Ill. R. S., Par. 744] **Examinations.**

(1) The Director, for the purpose of ascertaining the assets, conditions and affairs of any company, may examine the books, records, documents and assets of

(a) any company transacting, or being organized to transact, business in this State;

* * * * *

(d) any person having a contract, written or oral, pertaining to the management or control of a company as exclusive general agent.

(2) Every company or person being examined, its officers and agents, shall produce at its office its books, records and documents and all or any papers in its or their possession relating to the property, assets, business or affairs of the company. * * *

(3) The examiners designated by the Director pursuant to Section 402, shall make a full and true report of every examination made by them, which shall

comprise only facts ascertained from the books, papers, records or documents, examined by them or ascertained from the testimony of officers or agents or other persons examined under oath concerning the business and affairs and the assets of such company or person. * * *

* * * * *

Sec. 141 [Ch. 73, Ill. R. S., Par. 753] **Exclusive Agency Contracts.**

(1) No domestic company authorized to do an insurance business in this State shall make a contract with any person whereby such person is granted the exclusive right or privilege to solicit, procure, write or produce the entire insurance business for such company and collect premiums therefor unless such contract is filed with and approved by the Director. Failure of the Director to disapprove any such contract within thirty days after the same shall be filed with him, shall constitute his approval thereof. * * *

(2) The Director shall not approve any such contract which

(a) subjects the company to excessive charges for expenses or commissions; * * *.

Sec. 143 [Ch. 73, R. S., Par. 755] **Policy Forms—Life, Accident and Health.**

(1) No company transacting the kind or kinds of business enumerated in Class 1 of section 4 shall issue or deliver in this State a policy or certificate of insurance, * * * or use an application blank, in this State until the form and content of such policy, certificate, * * * or application blank has been filed with and approved by the Director. *It shall be the duty of the Director to withhold approval of any such policy,* certificate, * * * or application blank filed with him *if it violates any provisions of this Code, contains inconsistent, ambiguous or misleading clauses, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy.* In all

other cases the Director shall give his approval. Failure of the Director to act within thirty days after submission shall constitute approval. * * *

[Italics are ours here and elsewhere unless otherwise stated.]

Sec. 149 [Ch. 73, Ill. R. S., Par. 7611 **Misrepresentation * * * Prohibited.**

(1) No company doing business in this State, and no officer, director, agent, clerk or employee thereof, broker, or any other person, shall make, issue or circulate or cause or knowingly permit to be made, issued or circulated any estimate, illustration, circular or verbal or written statement of any sort misrepresenting the terms of any policy issued or to be issued by it or any other company or the benefits or advantages promised thereby * * *.

* * * * *

(5) Any company, officer, director, agent, clerk or employee thereof, broker, or other person who violates any of the provisions of this section, or knowingly participates in or abets such violation, shall be required to pay a penalty of not less than one hundred dollars, nor more than one thousand dollars, * * *."

"ARTICLE XVI—ASSESSMENT LEGAL RESERVE LIFE COMPANIES.

Sec. 254 [Ch. 73, Ill. R. S., Par. 866] **Scope of Article.**

This article shall apply to

(a) all companies transacting or being organized to transact the kind or kinds of business described in Class 1 of section 4 upon an assessment legal reserve basis;

* * * * *

Sec. 261 [Ch. 73, Ill. R. S., Par. 873] **Documents to Be Delivered to the Director.**

Upon the execution of the articles of incorporation there shall be delivered to the Director

(a) duplicate originals of the articles of incorporation;

(b) a copy of the by-laws adopted by the incorporators;

(c) forms of applications for insurance;

(d) forms of insurance policies, literature and advertisements;

(e) forms for guarantee fund subscriptions and certificates, if any; and

(f) two organization bonds or the cash or securities, provided for in section 262.

Sec. 267 [Ch. 73, Ill. R. S., Par. 879] **Subscription Requirements—Surplus.**

(1) No assessment legal reserve life company shall receive a certificate of authority from the Director to transact an insurance business unless it has five hundred bona fide applications from five hundred members for life insurance in the aggregate of at least two hundred and fifty thousand dollars, or unless it has two hundred and fifty bona fide applications from two hundred and fifty persons for life insurance in the aggregate of at least one hundred and twenty-five thousand dollars, and a surplus of at least ten thousand dollars.

* * * * *

Sec. 268 [Ch. 73, Ill. R. S., Par. 880] **Guarantee Fund.**

(1) Any domestic company subject to the provisions of this article may provide for a guarantee fund in the minimum sum of ten thousand dollars and the maximum sum of one hundred and fifty thousand dollars, for the purpose of its business or to enable it to comply with any requirements of the law. Such guarantee fund and such interest thereon as may have been agreed upon, not exceeding seven per centum per annum, shall not be a liability or claim against the company or any of its assets except as herein provided and such interest shall be paid and such principal shall be retired only out of the earned surplus of the company. * * *"

* * * * *

"ARTICLE XX—ACCIDENT AND HEALTH INSURANCE.

Sec. 355 [Ch. 73, Ill. R. S., Par. 967] **Accident and Health Policies—Provisions.**

No policy of insurance against loss or damage from the sickness, or from the bodily injury or death of the insured by accident shall be issued * * * until a copy of the form thereof and of the classification or risks * * * have been filed with the Director; nor shall it be so issued * * * until * * * thirty days after it has been so filed unless the Director shall sooner give his written approval thereto. If the Director disapproves the policy form he shall make a written decision stating the respects in which such form does not comply with the requirements of law * * * and it shall be unlawful thereafter for any such company to issue any policy in such form.

Sec. 356 [Ch. 73, Ill. R. S., Par. 968] **Form and Content of Policy.**

(1) No such policy shall be issued or delivered

* * * * *

(d) unless every printed portion thereof and of any endorsement or attached papers shall be plainly printed in type of which the face shall not be smaller than ten point; nor * * *

(f) unless the exceptions of the policy be printed with the same prominence as the benefits to which they apply.

Any portion of such policy which purports, by reason of the circumstances under which a loss is incurred, to reduce any indemnity promised therein to any amount less than that provided for the same loss occurring under ordinary circumstances, shall be printed in bold face type and with greater prominence than any other portion of the text of the policy.

Sec. 357 [Ch. 73, Ill. R. S., Par. 969] **Standard Provisions.**

Every such policy so issued shall contain certain standard provisions, which shall be in the words and

in the order hereinafter set forth and be preceded in every policy by the caption, 'Standard Provisions.' * * *

* * * * *

(4) A standard provision relative to time of notice of claim which may be in either of the three following forms: * * * Form (C) to be used in policies which insure against loss from both accident and sickness. * * *

* * * * *

(C) 4. Written notice of injury or of sickness on which claim may be based must be given to the insurer within twenty days after the date of the accident causing such injury or within ten days after the commencement of disability from such sickness.

(5) A standard provision relative to sufficiency of notice of claim which shall be in the following form and in which the insurer shall insert in the blank space such office and its location as it may desire to designate for such purpose of notice.

5. Such notice given by or in behalf of the insured or beneficiary, as the case may be, to the insurer at ..... or to any authorized agent of the insurer, with particulars sufficient to identify the insured, shall be deemed to be notice to the insurer. Failure to give notice within the time provided in this policy shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible."

"ARTICLE XXIV—DIRECTOR OF INSURANCE, HEARINGS AND REVIEW.

Sec. 401 [Ch. 73, Ill. R. S., Par. 1013] **General Powers of the Director.**

The Director is charged with the rights, powers and duties appertaining to the enforcement and execution of all the insurance laws of this State. He shall have the power

(a) to make reasonable rules and regulations as may be necessary for making effective such laws;

(b) to conduct such investigations as may be necessary to determine whether any person has violated any provision of such insurance laws; and

(c) to conduct such examinations, investigations and hearings in addition to those specifically provided for, as may be necessary and proper for the efficient administration of the insurance laws of this State.

* * * * *

Sec. 407 [Ch. 73, Ill. R. S., Par. 1019] **Court Review of Orders and Decisions.**

Any order or decision made, issued or executed by the Director, except an order to make good an impairment of capital or surplus or a deficiency in the amount of admitted assets, whereby any company or person is aggrieved, shall be subject to review by the Circuit Court of Sangamon County or the Circuit or Superior Court of the county in which the principal office in this State of the company aggrieved by such order or decision is located, or where the person so aggrieved resides. * * *''

''Article XXVIII—Final Provisions.

* * * * *

Sec. 446 [Ch. 73, Ill. R. S., Par. 1058] **Penalties.**

Any person who violates any of the provisions of this Code, or fails to comply with any duty imposed upon him or it by any provision of this law, for which violation or failure no penalty is elsewhere provided by the laws of this State, shall be fined not exceeding five hundred dollars.''

APPENDIX 2.

SYNOPSIS OF INSURANCE POLICIES IN SUIT.

The petitioner insurance company and its predecessors issued a number of different health and accident policies and also a number of endowment and life insurance policies (R. 809, 828-9). Two of the health and accident policies, the Security and the American Sentinel policies, are here under attack. Both policies were approved by the State and issued pursuant to State authority (R. 172). Photographic copies of the policies (reduced to half size) are set forth at page 469 of the transcript.

The Security policy was issued in several forms (all substantially alike) of which Forms L-101 and L-102 (Govt. Exs. 9 and 12) are here involved. The American Sentinel Policy was known as Form L-105 (Govt. Ex. 13).

Of the 13 policyholders alleged in the indictment to have been defrauded (omitting the 4 named in the counts that were dismissed) one had Security Policy Form L-101 (Govt. Ex. 9); 10 had Security Policy Form L-102 (Govt. Ex. 12); and 2 had the American Sentinel Policy (Govt. Ex. 13). Of 9 other policyholders testifying, one had a Security Policy Form L-101 and the 8 others had Security Policy Form L-102.

There is no substantial difference between Security Policy L-101 and L-102 except that in Form L-101 the benefit payable on death from a travel accident increases from $2,500 to $3,750 in 5 years, while in Form L-102 the increase is to $5,000. Otherwise, so far as here material, the 2 forms of Security Policy are the same.

The Security Policy.

The Security Policy was the first policy issued.

The material features of the policy are thus summarized:

In a box on the cover, under the heading "Important Notice," is the direction in bold face type—"**Read your policy carefully * * *.**"

On the first page, in large bold face type, is the heading, "**LIMITED ACCIDENT AND SICKNESS POLICY.**"

Diagonally across the front of the policy, in large colored capital letters, is the warning, "**THIS IS A LIMITED POLICY, READ IT CAREFULLY.**"

Then follow provisions relating to injuries from specific accidents, comprising the following:

Part I—a list of specific benefits for loss of life, loss of sight, etc., under the heading, in capital letters, "DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFITS—TRAVEL ACCIDENTS."

Part II—a description of the various types of accidents, to which the indemnities specified in Part II apply, each set forth in capital letters, including losses resulting from the wrecking of any of the following vehicles in which the insured might be a passenger: a passenger elevator, bus, private automobile (used for pleasure), motorcycle. The definition of "wrecking" is set forth in a prominent place at the top of the first page of the policy.

Part III—a schedule of alternative, optional indemnities for specific accidents listed in Part II.

Part VI—a provision for hospital benefits of $25 per week for 4 weeks for confinement in a hospital for injuries resulting from any cause listed in Part II.

The following provision is made for loss resulting from specified illnesses:

Part IX—a provision for $25 per week for a period of confinement beginning after the first 7 days and not exceeding 10 weeks because of any one of 56 listed diseases, including most of the common ailments.

This list was made up, presumably by the actuary, at the time of preparation of the first policy and is in the form approved by the Department of Insurance (Govt. Ex. 9, R. 469; Defts.' Ex. 10, R. 767).

There was testimony by a physician, put on the stand by the Government, that 21 of the diseases listed would not confine the patient for 7 days, or would kill him before that time expired (R. 135-137). But experience of the company indicates that at least, in some cases, confinement for the required period could and would result from some of the 21 diseases referred to (R. 190).

In any event, the remaining 35 of the diseases, including many common ailments, could cause confinement for the period specified (R. 137-138).

In addition to the above provisions for the special types of accidents and illnesses covered by the policy, the following indemnities are allowed for losses resulting from other accidents and illnesses not listed:

> Part IV—$100 for death from any unlisted accident.
>
> Part V—$25 for confinement of more than 30 days resulting from any unlisted accident.
>
> Part X—$15 for confinement (Form L-102, Govt. Ex. 12, R. 469; $25 is allowed in Form L-101, Govt. Ex. 9, R. 469) of more than 30 days from any illness not listed.
>
> Part XII sets forth the "Standard Provisions" as required by statute (Sec. 357, Ill. Ins. Code; Ch. 73, Ill. R. S. Par. 969). Standard Provisions 4 and 5, relating to notice, are all that are important here. They follow the statutory form set forth in Sec. 357, p. 69, *post.*
>
> Part XIII contains the "General Provisions" relating to rights and obligations of the insured, and certain definitions, exceptions and limitations applicable in construing the policy, of which the following only have any importance in this case:
>
> "* * *

(c) * * * After the age of sixty years all benefits and indemnities hereunder shall be reduced one-half.

(d) This insurance does not cover * * * (3) miners while at work; * * *; * * * (10) injuries fatal or non-fatal except drowning of which there shall be no mark or contusion on exterior of the body at the place of injury * * *; * * * (14) * * * post-traumatic infection * * *.

* * *

(j) The insurance under this policy shall not cover any loss or disability caused by diseases or illnesses affecting organs not common to both sexes. * * *''

All the foregoing qualifying provisions are in bold face type.

No fine type is used in the policy.

The American Sentinel Policy.

The ''American Sentinel Policy'' (Form L-105, Govt. Ex. 13, R. 469) is broader in its application than the Security Policy. The Sentinel Policy gives indemnity for loss from all types of injuries and sicknesses, subject to limitations and exceptions that are substantially the same as in the Security Policy.

The indemnity provisions and limitations and qualifications thereof are clearly set forth in capital letters or bold face type.

At the top of the policy in large, bold face capital letters, is a statement that the policy provides for **''INDEMNITY FOR LOSS OF LIFE, LIMBS, SIGHT AND TIME BY ACCIDENTAL MEANS OR TIME BY SICKNESS TO THE EXTENT HEREIN PROVIDED.''** Also in bold face capitals are the statements **''ACCIDENTAL DEATH BENEFIT $1,000''** and **''TRAVEL ACCIDENT DEATH BENEFIT $3,000.''**

In bold face type at the bottom of the first page of the policy is the statement, "**Benefits Reduced After Age 60.**"

The body of the policy is divided into 17 parts. Parts I, II and III set forth the conditions under which the single, double or triple indemnities are paid, for the specific losses listed. The single indemnity is payable for specific losses resulting from any accident; double indemnity, from specific losses suffered while riding in a pleasure automobile or other vehicle of the pleasure type, in case of the wreck of the vehicle; triple indemnity for losses suffered while riding as a passenger on a car or boat operated by a common carrier, in case of wreck of the car or boat.

So far as material, the other parts of the policy provide as follows:

> Part IV provides for indemnity, in case of loss of time resulting from accidental injury, of $50 per month for the first month, and $100 per month thereafter, up to a total period not exceeding 10 weeks, for the time the insured is disabled and confined to his house (except for necessary visits to the doctor's office).
>
> Part V provides for payment of $25 per month for the first 30 days and $100 per month thereafter, for a period of not exceeding 8 weeks, during which the insured shall be totally disabled and unable to attend to any labor or business because of an illness not excepted under the policy.
>
> Part VI provides for certain optional indemnities for specific injuries.
>
> Part VII provides for additional hospital benefits of $3. per day, not exceeding 15 days.
>
> Part VIII provides for an additional benefit of $10 for physician's or surgeon's services for which an indemnity is not otherwise payable under the policy.
>
> Part XI provides that accidental injuries resulting in certain diseased conditions including boils, septicaemia, and sprained or lame back, shall be paid for under Part V, relating to sicknesses—rather than under the accident provisions.

Part XII provides for expenditure of not more than $100 to locate relatives of the insured in case of emergency.

Part XIII sets up separately in bold face type, under the heading, "REDUCTIONS AND LIMITATIONS" certain exclusions and exceptions which are substantially the same as those set forth in Part XIII of the Security Policy (summarized pp. x-xi, *ante*).

Part XIV provides that after the insured reaches the age of 60 years, benefits and indemnities are reduced by one-half.

Part XVI contains the standard provisions prescribed by statute, including Provisions Nos. 4 and 5 relating to notice. (See Sec. 357, Illinois Insurance Code, Appendix 1, p. vi.)

Provision No. 4 is set forth in bold face type.

APPENDIX 3.

The Advertising.

The Government put in evidence 12 circular letters and 12 published advertisements relating to the policies in suit (R. 673-717).

The opinion filed (R. 919-37) quotes from 11 of the circular letters (only 6 of which were used) and from 2 of the published advertisements.

The advertisements do not purport to contain a statement of all the conditions and limitations in the policy advertised, or of the procedure that the insured must follow in presenting a claim. The purpose of each advertisement is to induce readers to send for the policy advertised, to examine it, and, if found satisfactory, to purchase it or retain it.

The superlatives used in describing this "remarkable policy," setting forth the "vital protection" afforded by it, and the necessity for getting "real cash money to pay doctor and medicine bills and regular living expenses," etc., are contained in the letters submitted to and approved by the Department of Insurance in June, 1910 (R. 760-4).

The opinion (R. 926) states that the evidence tends to show "substantial misrepresentation in the circular letters and advertisements"; and (R. 927) that "the testimony of policyholders tended to show that various of the inducements to the applicants contained in the letters and advertising had been actually misleading."

This is not borne out by the record.

1.

The Advertising Contains No Misstatement of a Material Fact.

(a)

The opinion states (R. 926) that the advertisements do not point out that the indemnities are "for certain specified accidents and certain specified illnesses."

That statement is not supported by the facts. Each of the advertisements that purports to list the benefits in the policies (except one of the published advertisements (R. 717) which speaks of "*graded*" benefits) states that those benefits are paid for "*specified*" accidents or illnesses, or that accidents or illnesses covered, or payments therefor, are "*as specified in the policy,*" "*all as stated in the policy,*" or the like,—substantially in accord with the form approved by the State Department of Insurance in 1940 (R. 760-763).

The policies advertised (R. 469 *et seq.*) set forth the limitations referred to.

(b)

The opinion (R. 926) cites as a misrepresentation the failure of the advertising to state that the specified maximum indemnities are for "travel" or "public carrier" accidents or the like.

The statement referred to was omitted from many of the advertisements, but not from all.

The first circular letter quoted in the Court's opinion includes a statement as to travel accidents which the opinion omits. The quotation in the opinion (R. 922) reads as follows:

> "Think of receiving $25.00 in cash each week to help you through a long period of disability * * *. In addition the policy provides up to $8,000 cash death benefits."

That quotation omits a sentence in the letter (indicated by the asterisks, following the phrase "long period of disability"), reading as follows (R. 673):

> "This Marvelous Policy pays death and disability benefits in case of accidents occurring while riding on a railroad car, elevated, subway, or interurban car, electric street-car, steamboat, taxicab, automobiles, motorcycles, horse-drawn vehicles, explosions, burning buildings, being struck by lightning, cyclone, or tornado—accidents in the home, And Many Other Liberal Generous Features."

This circular letter therefore contains all information that could be asked with respect to the kind of accidents covered by the Security Policy for which maximum indemnities are payable.

Other advertisements omit the statement that certain maximum benefits are limited to travel accidents—but rely on the qualification "*maximum*" or "*up to*" the amount stated, or on the phrases "*specified accident,*" "*specified illness,*" or "*as specified in the policy,*" or the like to indicate the limitation. Omission of the specific reference to "travel accidents" or "public carrier" accidents is not a misrepresentation of fact.

While the State Insurance Department (which has exclusive jurisdiction of this matter) in its letter of June 3, 1940 (R. 752-3) suggested that the qualification "public carrier" be added to describe an accidental death for which certain benefits were payable, no complaint was thereafter made by the Department to the omission of that phrase, or to the use of substitute phrases in later advertising—despite periodic examinations and exhaustive reports by the Department over the subsequent 8-year period, with respect to every detail of the business.

In view of the fact that the Department, in its letter of November 27, 1940 (R. 764-5) stated expressly that it was

not "waiving any of its duties with respect to the enforcement of the provisions of the Illinois Insurance Code concerning advertising which misrepresents the terms of the policies advertised," the failure of the Department to object to the advertising matter thereafter used is convincing evidence that there was no objection to it.

In the policies themselves, the limitations affecting the amount of the benefits and the character of accidents for which paid are set forth in boldface or capital letters (R. 469).

(c)

The opinion (R. 926) cites as a misrepresentation the fact that the advertisements contain no reference to a requirement in the policy that in certain cases a disability must persist for 30 days before maximum compensation or in some instances, any compensation, is payable therefor.

It is not fraudulent not to state all qualifications and limitations in an advertisement. The requirement of a minimum disability period of 30 days, more or less, is usual in health policies unless the premium is very high. Each advertisement refers the applicant to the policy for the specific terms under which benefits are payable.

(d)

The opinion (R. 926) criticizes the statement in the advertising that anyone between the ages of 16 and 75 could be insured, whereas the policy showed that all benefits are reduced by one-half after age 60.

Some of the circular letters sent out call specific attention to the fact that the benefits are reduced by half after age 60. See, for example, circular letter sent to Roman P. Penez and given by him to Nicholas P. Salazar (Govt.

Ex. 114; R. 715-6) not referred to in the opinion, which sets forth that half benefits are paid after age 60.

Other circulars did not call attention to that provision; but it is common in insurance policies and was set forth in boldface type in each of the policies here involved.

No one was misled by omission in the advertising of reference to reduction in benefits after age 60.

Of the 4 witnesses whose claims were reduced because of age, only one (Lowrey) had seen any advertising, and he testified that he knew when he got his policy that benefits were reduced by one-half after age 60 (R. 75).

Two out of the other 3 claimants mentioned also knew, when they received their policies, of the existence of the provision for reduction on account of age (R. 93, 555).

(e)

The opinion (R. 926) criticizes the statement in the advertising that no physical examination is required.

That statement is strictly accurate. No physical examination was required from any applicant for insurance.

Each applicant was required in his application for insurance to state that he was then in good health. If that statement is not true, it is the applicant, and not the insurance company, who is guilty of fraud. If the insurance company suspects that a fraud has been committed, investigation of the facts as to the health of the insured at the time of his application, is called for. The fact that such an investigation is made in no way detracts from the truth or significance of the fact that the applicant does not have to submit to a physical examination.

(f)

The opinion (R. 926) cites the fact that the advertising does not state that benefits would not be paid for disability resulting from a disease of an organ not common to both sexes.

Again the criticism is of the failure of the advertising to list limitations in the policy—which would be impracticable, if not impossible.

The attack is directed at the policy, not at the advertising. Without the limitation complained of, the premium for health insurance would be much higher.

The provision is a common one and while there has been considerable litigation as to its proper construction, its fairness or validity does not seem to have been questioned. (*Crisman* v. *Fidelity Health and Accident Mutual Insurance Co.*, 95 N. E. 2nd 776 [Ohio App.]; *Mutual Benefit Health and Accident Association* v. *Blaylock*, 87 A. L. R. 679 [Miss.]).

(g)

The opinion (R. 926) criticizes the statement that there is a "$100 emergency cash benefit."

Payment of this benefit is provided for in Part XI of the Security Policy and Part XII of the American Sentinel Policy, to pay expenses that might be incurred by an injured policyholder in getting in touch with friends and relatives. There is no basis for finding this statement to be a misrepresentation.

(h)

The opinion (R. 926) lists as a misrepresentation the statement that the "complete coverage" policy "had no loopholes, no ifs, ands or buts, no tricky wording, and no legal catch phrases."

The "complete coverage" or American Sentinel policy is a broad policy and is not restricted to specified illnesses. An examination of the policy form (Govt. Ex. 13 following Tr. 468) will show that reductions, limitations and conditions are set forth in boldface type under appropriate headings so that they could hardly be missed.

The designation of this policy as a "complete coverage" policy as well as the terms of the policy itself were approved by the State Department of Insurance.

The statement is not a misrepresentation.

(i)

The opinion (R. 926-7) also characterizes as untrue the statements that, "thousands of claims have been paid," "only a limited number of policies are to be issued," and "payments of benefits are guaranteed by a staunch old company."

The statement that the number of policies that could be issued is limited (if of any importance) is true—because of the requirements of the Illinois Insurance Code as to the maintenance of reserve and surplus funds. When those funds were unduly reduced, more guarantee certificates had to be sold, or the risks had to be reinsured to enable the company to continue issuing policies. In order to assure adequate reserves, all principal sums on outstanding policies were reinsured (R. 810).

The statement that the company was reliable was true. Financial requirements as to reserves and surplus were

complied with and claims were paid in strict accordance with the policy provisions. This appears from every report rendered by the Department of Insurance on investigation of the company (R. 775-6, 790-1, 807, 825).

Whether or not statements that the company was "old" or had paid "thousands of claims" were exaggerations, is of no importance. No one could have been hurt thereby.

The statements referred to could furnish no basis for a charge of fraud.

(j)

The opinion (R. 927) refers to the promise to furnish "quick cash when you need it most," but the Court states there was a delay of 52 days between the filing of a claim and the payment.

This is not a fair criticism. It conflicts directly with the finding by the Illinois Insurance Department for the years 1945-8 that *"policy claims appear to be paid promptly and in accordance with policy provisions"* (R. 825).

The fifty-two days' elapsed time referred to was from receipt of the preliminary "notice of sickness or injury on which a claim may be based" required by the statutory Standard Provision 4—not from the date of filing of the claim. The claim would not mature and could not be filed for a considerable period (at least 30 days in many instances) after the preliminary notice was given, and sufficient information to warrant payment of the claim might not be then forthcoming for an extended period.

The evidence does not show undue delay in payment of claims in accordance with policy provisions—certainly no delay from which a charge of fraud would be inferred.

2.

The Testimony Does Not Show That Any Policyholder Was Misled by the Advertising.

The opinion (R. 927) stated that "the testimony of the policyholders tended to show that various inducements to the applicants contained in the letters and advertising had been actually misleading."

The record does not support that statement.

Of the 22 policyholders testifying, 15 did not identify any advertising matter that they had seen, and made no claim that they had been misled by any advertising.

As to them, the case rests wholly on the charge that the state-approved policies were themselves deceptive and fraudulent.

Of the remaining 7 who identified circular letters or advertisements, seen by them before they bought their policies, none stated that he had been misled by this advertising.

(a)

Three of the policyholders (Edgar E. Hewatt, R. 66-72, 493-9; Emmitt P. Longan, R. 106-8, 618-629; and Major Brown, R. 99-100, 635-642), received one or both of two circular letters from defendant Johnson (R. 699-702) referred to in the Court's opinion (pp. 924-5) stating that the Security Policy paid "a maximum benefit of $5,000 for specified accidental death, or specified loss of hands, feet or eyesight; benefits of $25 each week for specified accidents; $100 per month — monthly benefits for disability due to sickness * * * as stated in the amazing Arcadia policy"; and asking the reader to send for and examine the policy.

Hewatt's claim was rejected because he failed to give notice for several months after his illness began, whereas,

by Standard Provision 4 (p. vi *ante*—required to be in the policy by express provision of the state law) notice must be given within 10 days. The letter rejecting the claim informed Hewatt that the failure to give notice would be waived and that the claim would be reinstated, as provided in Standard Provision 5 (p. vi *ante*), in the event it was not reasonably possible to give notice within the time specified.

There is no basis for a claim that Hewatt was misled by any statement in the circular he received. The criticism is of the policy provision calling for notice within 10 days, and of the statute requiring it.

Longan was hurt by a wreck of a truck which was a type of accident not "specified" in the policy and hence not calling for the indemnity payable for specified accidents. The word "specified" in the circular letter he received must be given some weight, and implies that there are accidents not specified, and not enumerated in the advertisement, for which the maximum benefit is not payable. He was asked in the circular to send for and to examine the policy before taking it.

Major Brown had bronchitis with influenza, confining him to his home for two weeks. This was likewise not a "specified" illness; and since the claimant was not confined to his home for 30 days, no benefit was payable. There is nothing in the testimony or correspondence to show that he was misled.

(b)

Raphael O. Lowery received two letters outlining the maximum benefits paid by the Security policy which he purchased (Govt. Exs. 59-60, R. 686-690).

He received one-half the benefit specified because he was over 60 years old. He testified that when he received the policy he read it and knew he would get only one-half (R. 75). He was not misled by the advertising.

There were 3 other witnesses (York, Long and DeSloover) whose claims were reduced because they were over age 60 but who did not identify any advertising that they had received. There was only one of those who had not known before making his claim, that benefits would be reduced by one-half because of age.

York had made a prior claim which was reduced one-half on account of age (R. 555). Long testified that he had read his policy when he got it and knew that it paid only one-half benefits after age 60 (R. 93). DeSloover, alone, said that he had not known that the claim would be reduced half after 60, but he did not identify any advertising that he saw and made no claim that he had been misled (R. 102-3).

(c)

Nicholas P. Salazar (R. 117-120; 504-13) was given a letter addressed to his brother-in-law, Roman P. Penez (Govt. Ex. 114; R. 715-6) stating that the Security policy "provides $25 weekly indemnity for sickness or accident and the maximum of $2,500 accumulating to $5,000 in five years for accidental death, all as specified in the policy * * * also * * * special sickness, accident and death indemnity, hospital benefits, surgeon fees and other vital protection." The letter stated that one-half benefits are paid after age 60, but that there are no increases in rates at any time.

The letter was thus very fair in stating the terms of the policy.

Salazar had eczema which was one of the illnesses specified by the policy, but his claim was rejected because he was not confined for 7 days, as required by the policy (R. 509).

There is nothing in the advertising that could have misled him.

(d)

Irene N. Dawson (R. 77-9; 574-590) received a circular letter (Govt. Ex. 79, same as Govt. Ex. 71, R. 703) calling attention to the fact that the policy pays "$5,000 maximum for accidental death, loss of feet or hands, with a maximum of $1,875 for the loss of one foot or hand * * * large cash monthly payments if disabled by sickness and accident all as explained and specified in the policy itself." The circular asked her to send for the policy and to read it carefully.

Miss Dawson stepped on a tack, resulting in an infection of her foot—although on the facts it is quite doubtful that the disability for which her claim was made actually resulted from the tack injury, instead of from a stroke or pulmonary tuberculosis with which she was afflicted (R. 579-587).

In any event, her claim was rejected because it was for a post-traumatic infection, excepted from coverage by specific provision of the policy.

If any exception is taken to the handling of this claim, it is on account of the provisions of the policy itself. There is nothing in the advertising that misstated any material fact or misled the claimant.

(e)

James Herbert Scarborough saw an advertisement in The Farmers Almanac (R. 717).

The advertisement was under a heading, "Cash for Sickness—for Accident," and stated that the policy "pays graded benefits of $2,500 for accidental loss of life, limb, sight, etc."

The claim was for an "acute" back sprain. The accident occurring while the claimant was on duty at a coal mine, requiring his confinement in a hospital for 16 days and disability for a somewhat longer period. The claim was re-

jected because there was no visible wound or contusion and the injury was received by a miner while at work, both of which were among the exceptions from coverage set forth in the policy.

While the term "graded benefits" in the published advertisement is not as explicit as the references in the circular letter to limitations in the policy, there is no ground for claiming that there was any misleading information given which affected this insured's claim. A short magazine advertisement could not list all qualifying provisions of the policy.

The Security policy was a limited policy and a warning to that effect was stamped upon it.

From the foregoing it appears that none of the seven witnesses who had seen any advertising matter before getting their policies, was misled thereby into buying a policy that he would not otherwise have taken. In each case, in compliance with the request in the circular or advertisement, he had sent for and examined the policy and decided to keep it. There is no evidence that the advertising deceived him.

The other fifteen policyholders who testified did not identify any advertising matter and made no claim to have been misled thereby into buying a policy.

The purpose of the advertising was to induce the reader of it to send for, to examine, and to keep the policy advertised—but if he did not like it he was given the right to return it.

The policy referred to sets forth the applicable terms, limitations and conditions, in the form prescribed by the state statute for the purpose of making sure that the pur-

chaser of the policy should not be deceived as to the provisions of his contract.

In considering whether a fraud was contemplated, the policy must be considered along with the advertising matter tendering it.

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In the Supreme Court of the United States

OCTOBER TERM, 1951

No. 507

ALFRED SYLVANUS, ARCADIA NATIONAL INSURANCE COMPANY and VOYLE CLARK JOHNSON, *Petitioners*

v.

UNITED STATES OF AMERICA

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINION BELOW

The opinion of the Court of Appeals (R. 919-937) is reported at 192 F. 2d 96.

JURISDICTION

The judgments of the Court of Appeals were entered on April 26, 1951 (R. 938-939), and petitions for rehearing (R. 945-1016) were denied on December 1, 1951 (R. 1017). The petition for a writ

of certiorari was filed on December 31, 1951. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1). See also Rules 37(b)(2) and 45(a), F.R. Crim. P.

QUESTIONS PRESENTED

1. Whether prosecution of petitioners for fraudulent use of the mails in selling insurance was barred by the provisions of the McCarran Act (15 U.S.C. 1011-1015), permitting the states to regulate the business of insurance.

2. Whether the evidence was sufficient to sustain the conviction of petitioners.

3. Whether the overt acts alleged in the conspiracy to have been committed within the period of limitations were acts in furtherance of the conspiracy.

STATUTES INVOLVED

18 U.S.C. 88[1] (35 Stat. 1096) provided:

> If two or more persons conspire either to commit any offense against the United States, or to defraud the United States in any manner or for any purpose, and one or more of such parties do any act to effect the object of the conspiracy, each of the parties to such conspiracy shall be fined not more than $10,000,

[1] This statute was repealed by the Act of June 25, 1948, c. 645, sec. 21 (62 Stat. 862), effective September 1, 1948, and is now covered by 18 U.S.C. 371.

or imprisoned not more than two years, or both.

18 U.S.C. 338[2] (35 Stat. 1130) provided in pertinent part as follows:

> Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, * * * shall, for the purpose of executing such scheme or artifice or attempting so to do, place, or cause to be placed, any letter, postal card, package, writing, circular, pamphlet, or advertisement, whether addressed to any person residing within or outside the United States, in any post office, or station thereof, or street or other letter box of the United States, or authorized depository for mail matter, to be sent or delivered by the post-office establishment of the United States, or shall take or receive any such therefrom, whether mailed within or without the United States, or shall knowingly cause to be delivered by mail according to the direction thereon, or at the place at which it is directed to be delivered by the person to whom it is addressed, any such letter, postal card, package, writing, circular, pamphlet, or advertisement,

[2] This section was also repealed by the Act of 1948 (see fn. 1, *supra*) and is now covered by 18 U.S.C. 1341.

shall be fined not more than $1,000, or imprisoned not more than five years, or both.

15 U.S.C. 1011 (59 Stat. 33) provides:

> Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

15 U.S.C. 1012 (59 Stat. 34, as amended, 61 Stat. 448) provides:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the

business of insurance to the extent that such business is not regulated by State law.

STATEMENT

On September 10, 1948, an indictment, containing eighteen counts (R. 2-19), was returned against petitioners, jointly, in the United States District Court for the Northern District of Illinois. The first seventeen counts (R. 2-16) charged unlawful use of the mails, between 1945 and 1947, in furtherance of a scheme to defraud by false representations regarding liberal accident and health benefits payable under policies of insurance. Count eighteen (R. 16-19) charged that, between 1938 and 1948, petitioners conspired to violate the Mail Fraud Act by agreeing to solicit mail orders for health and accident insurance policies purporting to provide liberal benefits, whereas, in fact, the policies contained very restricted provisions.[3]

Following a trial by jury, petitioners were found guilty on fourteen counts, including the conspiracy count (R. 374).[4] Sylvanus was sentenced to three

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[3] The conspiracy count alleged 15 separate overt acts occurring between October 14, 1938, and January 1, 1947 (R. 17-19). The last four overt acts charged involve the following: (1) incorporation of Arcadia Life and Casualty Company by Sylvanus on October 1, 1945; (2) election of Sylvanus as director of that company on October 1, 1945; (3) incorporation of petitioner Arcadia National Insurance Company on January 1, 1947; and (4) election of Sylvanus as its director on January 1, 1947 (R. 18-19).

[4] Counts 5, 7, 8 and 10 of the indictment were dismissed on motion of the Government at the end of its case (R. 29, 154).

years' imprisonment on each of the thirteen substantive counts and to two years on the conspiracy count, the terms to run concurrently (R. 377, 866); Johnson to eighteen months' imprisonment on each of the fourteen counts, the terms to run concurrently (R. 377, 867); and the corporation to a fine of $1,000 on each of the thirteen substantive counts, and $10,000 on the conspiracy count, the payment of $10,000 to discharge all fines on all counts (*id.*). On appeal, the judgments of conviction were affirmed (R. 938-939).

The evidence adduced by the Government tended generally to prove the following:

During the period between October 1938 and January 1939, Sylvanus and a group of associates organized in the State of Illinois the Arcadia Mutual Casualty Company, one of the predecessors of the corporate petitioner, for the purpose of insuring members "against bodily injury, disablement or death by accident and against disablement resulting from sickness or old age or any insurance appertaining thereto" (R. 36, 56; Gov. Ex. 1, R. 35, 380-382). Sylvanus became its president and actively managed its affairs. He was the only officer drawing a salary (R. 56; Gov. Exs. 50, 51, 51-A, R. 58, 662-665).[5]

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[5] In 1945, Arcadia Mutual consolidated with a reserve life insurance corporation (of which Sylvanus was also president) to form a new corporation, Arcadia Life and Casualty Com-

The company first sold only policies described as "Security Accident and Sickness" policies, having limited health and accident benefits, at a premium rate of one dollar a month or eleven dollars a year (Gov. Ex. 9, R. 40, 469; Gov. Ex. 51-A, R. 58, 671). In 1943, it began to issue "American Sentinel Complete Coverage Accident and Sickness Policy" providing for special double and triple indemnities (Gov. Ex. 51-A, R. 58, 671; Gov. Ex. 13, R. 40, 469).

On January 11, 1939, a general agent's contract was entered into by the company with one Loeb, who, shortly thereafter, with the former's consent, assigned it to International Insurance Agency, Inc. (Gov. Ex. 5, R. 39, 421-427). The agency, occupying the same offices as Arcadia, was operated by Sylvanus, who owned 51% of its stock and was its only salaried employee (R. 38, 145, 150). The contract authorized the agency to advertise and sell at its own expense insurance policies of Arcadia for commissions of 75% of the first monthly premiums and 60% of all subsequent premiums

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pany (R. 36, 56; Gov. Ex. 2, R. 35, 393-400). The following year the new organization changed its corporate name to Arcadia National Insurance Company, petitioner herein (R. 36, 56; Gov. Ex. 3, R. 35, 400-403; Gov. Ex. 50-51-A, R. 58, 665). The corporate set-up remained undisturbed and Sylvanus continued in control as president through the series of corporate changes (*id.*).

(Gov. Ex. 5, R. 39, 424, 425).[6] All advertising matter was, however, to be submitted to the insurance company for its approval (Gov. Ex. 5, R. 39, 426). The functions of underwriting and the settlement of claims remained in the company (Gov. Ex. 5, R. 39, 421, 422).

On February 24, 1944, Arcadia made a similar general agency contract with petitioner Johnson, who was doing business as the United States Insurance Agency (Gov. Ex. 8, R. 39, 458-468).[7] It authorized Johnson to advertise, sell and deliver at his own expense, the company's insurance policies in consideration of a commission of 70% of the first monthly premiums and 50% of all subsequent premiums (Gov. Ex. 8, R. 39, 463, 464, 467). The contract also provided that all advertising literature receive the company's approval and re-

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[6] Shortly after its date, the contract was amended, authorizing the agency to receive commissions of 75% of the first monthly premiums and 70% of all succeeding premiums on all Security policies sold (Gov. Ex. 5, R. 39, 432-433, 428; Gov. Exs. 9-12, R. 40, 469). By another amendment to the contract, the agency was authorized to advertise and sell the Complete Protection policies on commissions of 60% of all monthly premiums (Gov. Ex. 5, R. 39, 435; Gov. Ex. 13, R. 40, 469-470). There were further amendments to the contract which permitted the agency to receive, in addition to the commissions received on policies sold by it, an average of 10% overriding commission on all policies issued by the insurance company (R. 145, 149-150; also Gov. Ex. 5, R. 39, 427, 433).

[7] The Arcadia Mutual procured and paid for the agency license issued by the State of Illinois to the United States Insurance Agency (R. 44).

served to the company the functions of underwriting and the settlement of claims (Gov. Ex. 8, R. 39, 459-460, 465, 466, 467).[8]

The agencies undertook the promotion, on a nation-wide scale, of Arcadia's insurance business. Voluminous circular form letters, on Arcadia's letterheads, were sent through the mails and numerous advertisements were placed in various publications transmitted through the mails (R. 38, 42, 49-52, 54, 57, 61, 113; Gov. Ex. 176, R. 124, 724-728; Gov. Exs. 52-76, 79-81, 86, 111, 114, 119, 123, 175, R. 65, 114, 61, 69, 79, 75, 81, 107, 118, 100, 104, 94, 673-709, 710, 711, 715, 716, 717, 719). Between 1946 and 1947, Johnson's agency alone had arranged for the mailing of not less than one million advertisement postcards, in addition to hundreds of thousands of circular form letters (Gov. Ex. 176, R. 124, 725-726). Although all advertising was contracted for through the various agencies at their expense, the advertisements themselves, including the circular form letters, always carried Arcadia's name and were approved by Sylvanus

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[8] Arcadia Mutual had negotiated similar contracts with two other agencies to promote its "Security" type insurance on commissions of 70% on first monthly premiums and 50% and 55% of all subsequent premiums (Gov. Exs. 4, 6, R. 144, 39, 411-420, 436-445). And it had the same type of contract with still another agency, which was authorized to promote solely the "Complete Protection" type of policies at a commission of 50% of all premiums collected during the first year on policies sold by the agency and 45% on all subsequent premiums (Gov. Ex. 7, R. 39, 446-458).

(R. 38, 42, 56, 61; Gov. Ex. 176, R. 124, 728, 732). The nature of the advertising appears from the examples set forth in the opinion of the Court of Appeals (R. 922-927). The indictment charged (R. 6), and the evidence established the following representations with respect to the Security type policy (Gov. Exs. 52-57, 61, 67-76, 79, 111, 114, 119, 123, R. 65, 114, 69, 79, 107, 118, 100, 104):

(a) That the Security Policy would provide cash and sheltering protection to the holders of the said Security Policy if their income should be stopped on account of sickness or accident.

(b) That the Security Policy was easy to understand.

(c) That the Security Policy provides sympathetic, true-hearted protection against sudden emergency.

(d) That the payment of benefits is guaranteed by this old, reliable insurance company.

(e) That the Security Policy pays benefits of $5,000 to $8,000 for "accidental death" and $100.00 per month benefits for disability due to sickness or accident.

(f) That the sheltering protection of the Security Policy provides for doctor bills, medicine, hospital, nursing care, groceries and milk.

(g) That the defendants take the applicant's word that he is now in good physical condition.

(h) That the families of policyholders need never wonder about money on hand when sickness or accident strikes.

Actually, the benefits payable under the policies were very limited. The maxima of $5,000 and $8,000 for accidental death were payable only after the policy had been in force for five years, and only if the accident occurred while the insured was riding in a public carrier. The weekly indemnity of $25 for total disability caused by accident was limited to certain specified accidents, excluding most common accidents. The benefits for illness were payable for not more than eight weeks after the first seven days of illness, only if resulting from certain enumerated illnesses, and only if the insured was thereby prevented from transacting business, confined to his house and attended by a physician at least once a week.[9] (See Gov. Exs. 9-12, R. 40, 469.)

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[9] An expert testified for the Government that of the 55 specified diseases listed in Part IX of the policies, six of them are non-confining; two would confine for less than seven days; and that one is hereditary and consequently excluded from coverage by Part XIII, as being a pre-existing condition; that four of the afflictions listed would be fatal in less than seven days, and one does not occur in persons 16 years of age or over (R. 135, 136). In five instances, the list includes double medical designations for one disease (R. 135).

With respect to the Complete Protection type of policy, it was charged (R. 6-7), and proved, that the following representations were made (Gov. Exs. 58-60, 62-66, 80-81, 86, R. 65, 114, 75, 81):

(a) That the Complete Protection Policy had no loopholes, no ifs, ands, or buts, no tricky wording and no legal catch phrases to keep the policyholder from collecting benefits should sickness or accident befall.

(b) That the persons insured under the Complete Protection Policy can collect $100 a month for sickness or accident without limitation upon the type of sickness or accident.

(c) That the Complete Protection Policy pays $3000 for loss of limbs or sight, and $3000 for accidental death, without limitation upon the nature of the accident causing death.

(d) That the defendants have paid thousands of claims fully, quickly, and to the complete satisfaction of the policyholders.

(e) That the Complete Protection Policy gives its holders unlimited protection 24 hours a day, at work or play.

Actually, the $3,000 maximum for accidental death or dismemberment was payable only if the insured was "a fare-paying passenger within the enclosed part of a railway car, elevated, subway or

interurban railway car, electric street car or steamboat," and was injured or died, "independently and exclusively of disease and all other causes," as a result of a "travel accident," which wrecks the conveyance. If the accidental injury resulted in infection, payment was to be made as for sickness insurance, and not for accident. The monthly benefits for total disability, advertised as payable at $100 a month, were payable at the rate of $50 for the first 30 days, commencing with the seventh day after the first treatment by a physician. $100 was payable thereafter, but the total period of payment was not to exceed ten weeks. The monthly indemnity for illness was limited to certain diseases, payable at $25 for the first 30 days, commencing with the eighth day following treatment, with subsequent payments of $100 per month, the total period of payment not to exceed 8 weeks. (See Gov. Ex. 13, R. 40, 469).

During the period 1939-1946, there were 4,455 claims filed against Arcadia under the various policies, 71% of which were rejected (R. 147, 151, 154). Under the company's practice, it required an average of 52 days to process a claim, and the amounts paid on individual claims were small, even in cases of serious and crippling accidents (R. 147, 66-120; Gov. Exs. 15-34, 37, 47, R. 105, 75, 69, 104, 118, 94, 81, 92, 110, 112, 116, 98, 79, 89, 83, 87, 107, 109, 100, 101, 103, 96, 471-662). Once a claim had been disposed of, it was the practice for Sylvanus to reassess the risk involved in light of the new infor-

mation disclosed by the claim forms, and, if the insured's health had been impaired, to cancel the policy, no matter how long it had been in force (R. 47).

In 1940, the Department of Insurance of the State of Illinois notified Arcadia that "we note instances where general maximum statements are made regarding the terms of policies issued by your company which appear to be misleading if not misrepresentative," pointing out several instances (Gov. Ex. 180, R. 125, 738-739). Consequently, it had enjoined the company from issuing any advertising matter without the department's prior approval (*id.*). After a series of conferences between the department and the company, relative to a revision of the text of Arcadia's advertising literature, the department removed its restriction against its advertising (Gov. Ex. 180, R. 125, 734-765). But the literature that followed incorporated many of the features that the department found objectionable (*id.;* Gov. Exs. 52-76, 79-81, 86, 111, 114, 119, 123, 175, R. 65, 114, 61, 69, 79, 75, 81, 107, 118, 100, 104, 94, 673-709, 710, 711, 715, 716, 717, 719).

ARGUMENT

1. Petitioners contend (Pet. 25-33) that the McCarran Act (15 U.S.C. 1011-1015, *supra,* pp. 4-5) precludes prosecution of insurance companies for mail fraud. The McCarran Act was enacted for the specific purpose of offsetting the effect of the ruling in *United States* v. *South-Eastern Under-*

writers Association, 322 U.S. 533, that interstate insurance transactions constitute interstate commerce and are within the prohibitions of the federal antitrust laws. *Prudential Insurance Co.* v. *Benjamin,* 328 U.S. 408, 414, 429; S. Rep. 1112, 78th Cong., 2d Sess.; H. Rep. 143, 79th Cong., 1st Sess.; 91 Cong. Rec. 1474-1489. The purpose of the Act was to preserve the "continued regulation of the business of insurance by the respective States". H. Rep. 143, 79th Cong., 1st Sess., p. 2.[10]

Nothing in this legislation or its history suggests a purpose of Congress to permit insurance companies to use the mails in violation of the United States postal laws. The Mail Fraud Act does not purport to regulate an insurance business or any other business, whether traditionally within the scope of state or of federal regulation. The act is grounded on the constitutional power of Congress to regulate post offices and post roads (U. S. Const., Art. I, sec. 8, cl. 7). It undertakes merely to regulate the mails and does not proscribe the fraudulent

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[10] "It is not the intention of Congress in the enactment of this legislation to clothe the States with any power to regulate or tax the business of insurance beyond that which they had been held to possess prior to the decision of the United States Supreme Court in the *Southeastern Underwriters Association case.*" Id. p. 3. See also S. Rep. No. 1112, 78th Cong., 2d sess.: "[The bill] would affirm the intent of the Congress that the regulation of the business of insurance remain within the control of the several States, *where it now exists*" (p. 3); "*the preservation* of State regulation of insurance" (p. 7). (Emphasis supplied.)

scheme for the execution of which the mails are employed. Congress has forbidden the use of the mails "in furtherance of a scheme that it regards as contrary to public policy, whether it can forbid the scheme or not." *Badders* v. *United States*, 240 U.S. 391, 393. Thus, the application of the Mail Fraud Act to the use of mails in execution of a fraudulent scheme conducted by a duly licensed insurance company, or any other lawful enterprise, does not have the effect of invalidating, impairing or superseding any state legislation regulating the business. Accordingly, as the court below pointed out, if petitioners, "in conducting an otherwise legal business, engaged in a fraudulent course of conduct, whether that conduct was or was not approved by the state administrative office is wholly immaterial" (R. 931).[11]

2. The sufficiency of the evidence to support the conviction sufficiently appears from the facts set

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[11] The court did say that if it were a fact that the state had previously approved the advertising literature used by petitioners, such fact would have been "one of the circumstances bearing upon the question of good faith, *Hawley* v. *United States*, 133 F. 2d 966 (C. A. 6), but not decisive of the ultimate issue" (R. 931). However, after reviewing the advertising material used by petitioners following the insurance department's revision, the court below found that it "contained most if not all the features which the Department had previously found objectionable" (R. 928; compare R. 734-765 with R. 637-707, 710-711, 715-717, 719). The trial court instructed the jury that state approval was a circumstance to be considered on the question of petitioners' good faith (R. 370).

forth in the Statement, *supra,* and the opinion of the Court of Appeals (R. 922-930).

There is no merit in petitioners' contention (Pet. 38-40) that, since the advertisements and circulars did not purport to include all the terms of the policy, but referred the reader to the policy itself for specification and amplification, such advertisements could not be held to be deceptive. The issue is not whether a policyholder was bound by the limited provisions of the policy, but whether the advertisements were calculated to mislead the public as to the true nature of the policy and the scope of coverage afforded thereunder. The purpose of the Mail Fraud Act is to protect the public against all intentional efforts to despoil. *Durland* v. *United States,* 161 U.S. 306; cf. *United States* v. *Buckner,* 108 F. 2d 921 (C.A. 2), certiorari denied, 309 U.S. 669. Of course, once the insured had accepted the policy he would be bound by its terms in any civil litigation based on the policy as was the case in *Bowers* v. *Washington Times Co.,* 65 F. 2d 200 (C.A.D.C.), which petitioners cite (Pet. 38-40) as being in conflict with the decision of the court below. The two situations are, however, quite dissimilar. Whatever may be their civil liability, petitioners cannot escape their liability under the Mail Fraud Act by claiming that the public should have suspected their honesty. Accordingly they were not entitled to have the jury instructed that it was incumbent upon the insured to read his policy in order to ascertain the conditions contained therein.

3. Petitioners attack the conspiracy count (Pet. 11-13, 35-37) on the ground that the four overt acts alleged to have been committed within the period of limitations are insufficient, "because none commits the supposed conspirator to the criminal act alleged to have been contemplated." In view of the fact that the prison sentences of the individual petitioners were concurrent and payment of the fine imposed on any ten of the substantive counts would discharge the liability of the corporate defendant, this issue, relating only to the conspiracy count, could not affect the judgment in this case. In any event, the various acts relating to the organization and operation of the series of Arcadia companies, their financing and the negotiation of the agency contracts, although innocent in themselves, clearly constituted "overt acts," since they were done with the purpose of putting the unlawful agreement into effect. *United States* v. *Holte,* 236 U.S. 140, 144; *Kaplan* v. *United States,* 7 F. 2d 594 (C.A. 2), certiorari denied, 269 U.S. 582; *Collier* v. *United States,* 255 Fed. 328 (C.A. 5).

These acts were not, as in *Fiswick* v. *United States,* 329 U.S. 211, 217, acts tending merely to continue the results of a completed conspiracy; they were acts in furtherance of a continuing conspiracy. The prosecution was therefore not barred until three years after the commission of the last overt act alleged and proved. *Brown* v. *Elliott,* 225 U.S. 392; *United States* v. *Johnson,* 165 F. 2d

42 (C.A. 3), certiorari denied, 332 U.S. 852; *United States* v. *Lewis,* 161 F. 2d 683 (C.A. 2).

CONCLUSION

The judgment below is correct, and no conflict of decisions or question of general importance is involved. It is therefore respectfully submitted that the petition for a writ of certiorari should be denied.

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CHARLES ELMORE CROPLEY

IN THE

Supreme Court of the United States

OCTOBER TERM, 1951.

No. 507

ALFRED SYLVANUS, ARCADIA NATIONAL INSURANCE COMPANY AND VOYLE CLARK JOHNSON,

Petitioners,

vs.

THE UNITED STATES OF AMERICA,

Respondent.

REPLY BRIEF OF PETITIONERS IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT.

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The Petition for Certiorari (pp. 17-21) sets forth four reasons why the decision of the United States Court of Appeals for the Seventh Circuit should be reviewed. All involve important questions of Federal law not heretofore decided by this Court; two of them have resulted in a conflict of decision between Courts of Appeal.

The Government's brief only emphasizes the necessity of clarification of the Federal statutes involved and leaves unresolved the conflicting decisions of the Courts of Appeals.

I.

The Question of Construction of the McCarran Act.

The McCarran Act provides that "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance * * * unless such Act specifically relates to the business of insurance * * *."

Sec. 1012, Title 15, U. S. Code.

The McCarran Act thus excludes from the application of *every* act of Congress (not specifically relating to insurance) every matter connected with the conduct of an insurance business which is subject to regulation under the State law.

There could hardly be a clearer instance of interference with State regulation of the insurance business than the decision in this case.

While the use of the mails gives the United States Courts jurisdiction, the conviction rests on a basic adjudication that the purpose or "scheme," to effect which the mails were used, was fraudulent, *i. e.*, in the instant case: (1) that the insurance policies (despite express approval thereof by the State authorities) were "cunningly worded" and deceptive; and (2) that the advertising matter published and circulated was so misleading as to constitute a fraud.

Both the policies and the advertising matter are subject to exclusive regulation by the State. The effect of the prosecution is thus to supersede entirely the State law and to condemn as fraudulent, acts in the conduct of an insurance business which are approved by the State, or for the doing of which the State law provides a penalty.

Without regard to legislative history, the language of the McCarran Act expressly prohibits such an interference with the State's powers over the insurance business.

But the legislative history is in accord with the language of the statute, not opposed to it. As stated by the House Committee in its report on the Act, its purpose was to assure those engaged in the insurance business that they could look to the State law and to State authorities for direction as to what they could or could not do, and that compliance with State regulations would not "subject insurance executives to both civil and criminal prosecutions" under Federal statutes.

U. S. Code, Congressional Service (1945) p. 671.
(Quoted in our Petition at p. 32.)

In the instant case, the insurance policies claimed to be fraudulent were expressly approved by the State; the advertising matter, if not all expressly approved, was passed without adverse comment in a series of exhaustive reports of the Illinois Insurance Department filed periodically during the period 1941 to 1948 (R. 772-842); and the alleged delay in payment of claims, of which the Government complains (Govt. Brief, p. 13) was found by the State to be nonexistent in a report stating that "policy claims appear to be paid promptly and in accordance with policy provisions." (R. 825.)

The case is similar to *North Little Rock Trans. Co.* v. *Casualty Reciprocal Exchange,* 181 Fed. (2d) 174 (C. A. 8; Cer. den. 340 U. S. 823), involving a suit for triple damages under the Sherman Act.

In that case, the defendant insurance companies were engaged in an interstate business. It was contended by the plaintiff, that, since interstate commerce is subject to exclusive Federal jurisdiction, the insurance companies were subject to suit under the Federal anti-trust laws for damages resulting from a monopolistic agreement affecting such commerce, entered into in Arkansas and relating to the conduct of the interstate insurance business, even though the agreement itself was subject to the regulations of the Arkansas law governing the conduct of that business.

As a defense, the insurance companies contended that they were not liable because (p. 175) "the conduct of which the plaintiff complained was regulated by the laws of the State of Arkansas * * * and that because of the Act of March 9, 1945 * * * known as the McCarran Act, the Sherman Act did not apply to the insurance business insofar as it was regulated by the State."

The Court sustained the defense and held that the McCarran Act barred the suit under the Federal statute, because its effect, if successfully prosecuted, would be to invalidate, impair, or supersede the provisions of the Arkansas law regulating the conduct of an insurance business.

The decision in the *North Little Rock* case is in direct conflict with the decision in the instant case. The jurisdiction of Congress over the mails is no more exclusive than its jurisdiction over interstate commerce. But the McCarran Act provides that no statute exercising such jurisdiction shall be construed to extend to acts relating to the conduct of a state-regulated insurance business unless such statute specifically relates to that business. If jurisdiction cannot be extended to acts performed in the conduct of an insurance business in a case involving interstate commerce, it cannot be so extended in a case involving the use of the mails. In either case, the prosecution, if successful, invalidates, impairs, or supersedes the State law relating to insurance.

Badders v. *United States,* 240 U. S. 391, cited in the Government's brief (p. 16) holding that a prosecution may be maintained under the mail fraud statute, even though based on a local fraud, is not in point. The principle laid down in that case is similar in effect to that applied in *United States* v. *Southeastern Underwriters,* 322 U. S. 533, in enforcing the Sherman Act. The purpose of the McCarran Act was to prevent further application of that principle, and thus to change the pre-existing law, in cases relating to the conduct of a state-controlled insurance business.

The question here involved, as to construction of the McCarran Act, is important and should be decided by this Court. This is particularly true in view of the conflict in the decisions of the Circuit Courts of Appeal.

II.

The Question As to the Sufficiency of the Conspiracy Count and of the Proof Thereunder.

The "overt act" required to sustain a conviction for conspiracy must be of such character that it commits the party performing it to the crime contemplated, so that he may not thereafter withdraw and be innocent; and it must be a positive step "to effect the object of the conspiracy."

Sec. 371, Title 18, U. S. Code.
United States v. *Britton*, 108 U. S. 199 (204-5).
United States v. *McLaughlin*, 169 Fed. 302 (307) (D. C. D., Minn.).

The supposed "overt acts" (R. 17-19), on which the charge of conspiracy rests here, are summarized at pages 12-13 of our petition. None of them has any connection with the use of the mails which was the supposed object of the conspiracy.

The only acts alleged to have been performed within the three-year limitation period were the incorporation of Arcadia Life and Casualty Company and its successor, and the election of Sylvanus as director. Those acts do not commit the defendants to the use of the mails for a fraudulent purpose or tend to carry into effect a design so to use them.

About the only act that could constitute an overt act in a mail fraud case would be the mailing of a letter, or at least some act connected therewith. It is the act of mailing a letter that is referred to in *Badders* v. *United States*,

240 U. S. 391 (393), cited by the Government, as the "*overt act*" which Congress may regulate.

There is thus no overt act charged or proved that would support the conspiracy count.

But the Government contends that any error in sustaining the conspiracy count was not material because there were substantive counts to support the conviction. (Government's brief, p. 18.)

That contention cannot stand. Much of the evidence introduced against the individual defendants would not have been admissible against one or the other of them, except for the conspiracy charge. There is no ground for the assumption that the jury was not influenced by that evidence or by the argument and instructions relating to that charge.

As this Court said in *Fiswick* v. *United States*, 329 U. S. 211 (218), (quoting from *Kotteakos* v. *United States*, 328 U. S. 750), in denying a contention that a like error in sustaining a conspiracy count was harmless:

> "But if one cannot say, with fair assurance, after pondering all that happened without stripping the erroneous action from the whole, that the judgment was not substantially swayed by error, it is impossible to conclude that substantial rights were not affected. The inquiry cannot be merely whether there was enough to support the result, apart from the phase affected by the error. It is rather, even so, whether the error itself had substantial influence. If so, or if one is left in grave doubt, the conviction cannot stand."

If the conspiracy count and the evidence offered had been excluded, the case would have been essentially different.

For the reasons stated in the brief in support of our Petition (pp. 35-37), we submit that the Court should pass on the question here raised.

III.

The Conflict in the Decisions As to the Duty of the Insured to Read His Policy and to Be Bound by the Terms Thereof.

The decision in this case is in direct conflict with the decision of the Court in *Bowers* v. *Washington Times,* 65 Fed. (2d) 200 (C. A. Dist. Col.), as to the duty of the insured to read his policy.

While the *Bowers* case was a civil suit, it was based on fraud rather than contract. In that case, Bowers, the applicant for insurance, had applied for the policy and paid for it, but was accidentally killed before it was issued to him. His administrator sued to recover $10,000 for accidental death on the ground that the advertisement, as a result of which the application for the policy was made, stated that $10,000 was the benefit for accidental death. The insurance company defended on the ground that the policy advertised, and tendered to the insured or his estate, paid $10,000 for deaths from travel accidents only, and paid only $500 for death from the accident there involved, and hence that $500 was the limit of recovery.

The advertisement read (p. 201):

> "Protect your family. Insure your life. One dollar provides protection for $10,000 to subscribers of the Washington Times and the big Sunday Washington Herald. A new and better accident policy in the Continental Life Insurance Co. (St. Louis, Mo.) For loss of life, $10,000. For loss of both eyes, $10,000. For loss of both hands, $10,000. For loss of both feet, $10,000. For loss of one hand and one foot, $10,000. For loss of one hand and sight of one eye, $10,000. For loss of one foot and sight of one eye, $10,000. For loss of one hand, $2,500. For loss of one foot, $2,500. For loss of one eye, $2,500. For loss of time per week, $20.00. With other provisions."

The reference to the policy in the advertisement in the *Bowers* case was thus not as specific as in the advertising matter in the case at bar, where each advertisement and circular letter tendered the policy for examination and referred the applicant to the policy for the specific terms of the insurance provided. Nonetheless the Court (in the *Bowers* case) held that the insured or his administrator was required to read the policy tendered and was bound by its terms limiting recovery for the death in that case to $500. As to this the Court said (p. 202):

> "The advertisement sets out in a prominent manner that the policy in question would contain other provisions. The insured was thereby notified that he should examine the policy in order to fully acquaint himself with its terms.
>
> It appears that the policy which was tendered to appellant after the death of decedent was of the standard type and form issued by the defendants in such transactions and referred to in the receipt which decedent received in his lifetime. There was no fraud or concealment in the character of the policy, nor were the terms of the advertisement such as to mislead any reasonably careful person."

That holding is exactly contrary to the decision of the Court of Appeals in the instant case that the insured was not bound to read his policy, and that the trial court did not err in refusing to give an instruction to that effect.

The argument in the Government's brief (p. 17) that there is no conflict between the two decisions because the *Bowers* case is a civil case is based on a misapprehension of the *Bowers* case. If there is any difference, a higher degree of proof of fraud is required in a criminal case than that required in a civil case.

We submit that the Court should grant a writ of certiorari in this case and that the decision of the Court of Appeals herein should be reversed.

Respectfully submitted,

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